IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA
AT CHARLESTON

THE CITY OF HUNTINGTON, Plaintiff, v. AMERISOURCEBERGEN DRUG CORPORATION, et al., Defendants.	:	Civil Action No. 3:17-cv-01362
CABELL COUNTY COMMISSION, Plaintiff, v. AMERISOURCEBERGEN DRUG CORPORATION, et al., Defendants.	:	Civil Action No. 3:17-cv-01665

BENCH TRIAL - VOLUME 21
BEFORE THE HONORABLE DAVID A. FABER, SENIOR STATUS JUDGE
UNITED STATES DISTRICT COURT
IN CHARLESTON, WEST VIRGINIA

JUNE 7, 2021

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PROCEEDINGS had before The Honorable David A. Faber, Senior Status Judge, United States District Court, Southern District of West Virginia, in Charleston, West Virginia, on June 7, 2021, at 9:00 a.m., as follows:

THE COURT: Good morning, everybody.

Dr. O'Connell, are you here?

THE WITNESS: Yes.

MS. QUEZON: She is, Your Honor.

MS. MCCLURE: Your Honor, before we get started, the defendants do have one issue to raise that's unrelated to Dr. O'Connell.

THE COURT: Okay.

MS. MCCLURE: Pursuant to the parties' joint trial stipulation, which was entered by the Court at ECF 1029, the parties are each obligated to provide notice under Section 6 of that document regarding witnesses and who's going to be called the following week.

So Monday at 7:00 p.m. witnesses are due for the following week. For witnesses this week, that would be in the week of June 7th, disclosure would have been due this past Monday, May 31st.

As Your Honor is, of course, aware, we were off this past week. Plaintiffs did provide a list on May 31st of eight witnesses for this week.

Yesterday evening plaintiffs for the first time disclosed that they intend to call a marketing expert, Jakki Mohr, this week, Dr. Jakki Mohr on Thursday, this Thursday, contending that there are scheduling issues that require that she be called this week.

Your Honor, pursuant to the parties' stipulation, the plaintiffs were obligated to give notice on May 31st of witnesses for this entire week, June 7th. They did not. They disclosed O'Connell, Dial, Davies, Joe Rannazzisi, Gordon Smith, Lacey Keller, Dr. Keyes, and Saxe, with Keller and Keyes being experts.

So now just six, six days after the disclosure was due and three days before they intend to call her, they've added this purported expert, Jakki Mohr, to their list.

This violates the parties' stipulation. It violates the Court's order. And we object to this being insufficient notice under the stipulation.

And so, Your Honor, we request an order from the Court that would say -- we have no objection to Dr. Jakki Mohr coming next week. They've disclosed her in plenty of time for next week.

Our objection is that this late disclosure simply violates the rule. It's inexcusable, provides us with insufficient notice to prepare for an expert this week with that little notice.

THE COURT: Okay. Let me hear from your opponent, Mr. Ackerman.

MR. ACKERMAN: I'll go up to the podium, Your Honor.

THE COURT: So I don't have to peek around the screen.

MR. ACKERMAN: Exactly. It's a whole lot easier from up here.

Your Honor, there's no gamesmanship here. I can advise the Court, as I advised defendants yesterday, exactly what happened in discussions with Dr. Mohr.

We learned that Dr. Mohr has a scheduling conflict due to family events. Dr. Mohr is located in Missoula, Montana. There aren't direct flights, unfortunately, from Missoula to Charleston, West Virginia. So Dr. Mohr's travel here and back requires some significant planning.

We told the defendants as soon as we could. We're not putting her up today or tomorrow. We're going to do it Thursday afternoon or Friday morning as we advised the defendants.

They have notice of this witness. She's been on our witness list. She's an expert. She's a -- she filed an expert report. They took her deposition.

This is not a habitual problem. This is a one-time issue due to a scheduling conflict and we would ask the

Court's indulgence.

MS. MCCLURE: May I respond, Your Honor?

We don't think there's any gamesmanship. I'm -- my argument is not dependent on gamesmanship. They agreed to this time provision. Their witnesses' schedule are within their knowledge and control, not ours.

I don't even have to prove prejudice because it's their stipulation that we agreed to as well and it was entered as a court order.

That said, the prejudice is essentially baked into the timing that is set forth in that schedule. And, so, Your Honor, they, they can call her next week. We have no objection to that.

The fact that there's no gamesmanship here does not resolve the issue. I don't think there is gamesmanship. I understand there's a scheduling problem. I accept that for purposes of this argument. But that doesn't fix the problem that we were entitled to notice that was not six days late.

THE COURT: What's her scheduling conflict, Mr. Ackerman?

MR. ACKERMAN: She has, she has not visited family due to the pandemic and had made plans to visit family that she hasn't seen in a year. We're trying not to alter her family visit plans.

Now, Your Honor, I would note that if she was going to

testify today and we had disclosed her on last Monday, they would have had seven days notice. We disclosed her yesterday. Monday, Tuesday, Wednesday, Thursday, that's four, five days notice. It's not that much different.

MS. MCCLURE: Your Honor, they disclosed eight witnesses this past Monday who we've been spending our time preparing for based on their representations required under the stipulation that that is who they were going to call.

Now they've added at the last minute a ninth witness into the mix who is an expert witness with insufficient notice.

And I don't believe that family issues -- we all have had trouble seeing family during the pandemic. This is a paid expert who should be able to arrange her schedule, and the plaintiff should be able to work with her to have her called next week.

THE COURT: If you put her at the end of your batting order here, you probably won't get to her this week anyway, will you, Mr. Ackerman?

MR. ACKERMAN: Well, I hope, Your Honor, -- we had put her at the -- in the eighth slot of the, of the ninth slot batting order. Our hope was that as we plotted out the week, we thought if we got to her, it would be Thursday afternoon or Friday morning.

MS. MCCLURE: And, Your Honor, I believe what

they're doing is actually rearranging the schedule to ensure that she goes this week, meaning that --

THE COURT: Well, you had notice of all the other witnesses except her, right, that they plan to call this week?

MS. MCCLURE: We had notice of eight witnesses that they plan to call this week. The key here is that this is a marketing expert, a paid, a paid expert.

My microphone has gone off.

And, Your Honor, we've been spending time pursuant to the stipulation preparing for the witnesses that they did indicate they plan to call.

THE COURT: Well, --

MS. MCCLURE: And a family obligation simply to us for a paid expert does not warrant the undue prejudice to defendants.

THE COURT: Well, I don't see any significant danger of undue prejudice. And if you get to her by Friday, I'll let her testify on Friday, Mr. Ackerman.

MR. ACKERMAN: Thank you, Your Honor.

THE COURT: Okay.

Good morning, Dr. O'Connell.

THE WITNESS: Good morning, Your Honor.

THE COURT: And, of course, you're still under the oath you took several days ago to tell the truth in this

trial.

THE WITNESS: Yes, sir.

THE COURT: Mr. Hester, you may proceed.

MR. HESTER: Good morning, Your Honor. It's good to be back.

CROSS EXAMINATION

BY MR. HESTER:

Q. Good morning, Dr. O'Connell.

A. Good morning.

Q. Welcome back. Dr. O'Connell, in your testimony before the break you had described various opioid related programs, treatment programs and the like at Cabell and Huntington. Right? And I'm going to want to circle back to those and discuss them in more detail.

But I'd first like to set the table of your relationship within the Division of Addiction Sciences and, more broadly, within Marshall.

THE COURT: Let me interrupt you. I'm sorry, Mr. Hester. But apparently we've got a technical -- our first technological glitch. We don't have anything in the overflow courtroom.

Now, do we need to fix that before we go ahead?

Have we got somebody working on it?

THE CLERK: Yes.

THE COURT: Well, let's go ahead and make the best

of it here. I don't want to interrupt your cross here, Mr. Hester. It's already been interrupted for 10 days.

MR. HESTER: I had a chance to polish it to a fine queue, Your Honor.

MS. QUEZON: And, Your Honor, in that same vein, I don't want to interrupt Mr. Hester either and I believe he's going to use the board. Would it be all right if I reposition myself so that I can --

THE COURT: Sure.

MS. QUEZON: Thank you so much.

THE COURT: Get where you can see, absolutely.

MS. QUEZON: Thank you.

MR. HESTER: Your Honor, may I approach?

THE COURT: Yes, you may.

BY MR. HESTER:

Q. Dr. O'Connell, we've handed you what's been marked as MC-West Virginia-02134 which appears on its face to be Marshall Family Medicine Annual Report for fiscal year 2018.

I take it you're familiar with this report, Dr. O'Connell?

A. I'm familiar predominantly with my section of the report.

Q. And you were involved in drafting the sections of the report that relate to the Division of Addiction Sciences;

correct?

A. Correct.

Q. And this report -- this annual report on Marshall Family Medicine is issued every year?

A. It is.

Q. And Dr. Petrany is the Chair of the Department of Family Medicine which is also called Marshall Family Medicine; is that right?

A. Can you repeat that?

Q. Sure. It is -- I'm trying to understand the nomenclature a little bit. There's a Department of Family Medicine; correct?

A. Correct.

Q. And that's also called the Marshall Family Medicine; is that right?

A. It -- the way it's situated in the Joan C. Edward's School of Medicine, we have the Department of Family and Community Health. And how they practice as physicians is under Marshall Health which is then the Family Medicine Department.

Q. So Marshall Family Medicine is the unit within Marshall Health? Is that fair to say?

A. Correct.

Q. And Marshall Family Medicine includes the Division of Addiction Sciences where you work; correct?

A. Correct.

Q. And Marshall Health is not a part of the City of Huntington or Cabell County; correct?

A. Correct.

Q. And Marshall Health does not receive any funding from the City of Huntington or Cabell County; correct?

A. I do not know.

Q. You're aware that, that the Marshall entities don't receive funding from Cabell County?

A. I don't believe so, but I'm not involved in the budget of the school.

Q. So this annual report is prepared each year I take it; correct?

A. Correct.

Q. And it's prepared by persons with knowledge of its subject matters covered; correct?

A. Each division within the department is responsible for detailing their section and reporting that.

MR. HESTER: We would move, Your Honor, at this time for MC-WV-02134 to be admitted into evidence.

THE COURT: Is there any objection to this?

MS. QUEZON: I would object to both relevance and hearsay, Your Honor.

MR. HESTER: Your Honor, it's, it's a business record. It's a record of a regularly conducted activity.

MS. QUEZON: I don't believe that foundation has been laid, Your Honor.

THE COURT: Well, you haven't laid -- if you want it in as a business record, you have to go through the hoops, Mr. Hester.

BY MR. HESTER:

Q. So this report, this annual report is prepared each year by Marshall Family Medicine; correct?

A. The report is compiled by individuals in -- within the department and the large organization, or just within Family Medicine.

Q. And it's prepared each year by at the time -- at the time it's prepared, the persons who prepare it have knowledge of the materials they're writing about in this annual report; correct?

A. Individuals within each of the divisions compile their section, and then our admin team put it together.

Q. And Marshall Family Medicine publishes this annual report each year as a record of its activities during the year; correct?

A. I don't know where it goes.

Q. Do you know it's published each year?

A. I do not know where the final division input goes.

MR. HESTER: Well, I would again, Your Honor, move it into evidence as a business record.

THE COURT: I'm going to admit it. It's admitted as a business record.

BY MR. HESTER:

Q. And if you turn to Page 7 of this document, Dr. O'Connell, -- and just to help you orient, I'm going to use the numbers at the bottom left corner to lead you through. You can see there it says 2134.7. Do you see that?

A. Yes, I do.

Q. So that's where -- so we'll be on the same page.

And it states here at the bottom of Page 7 that, that Marshall Family Medicine had established a new Division of Addiction Sciences built upon four main foci activity: Research, education, clinical service, and community engagement.

Do you see that?

A. Yes.

Q. And is that a fair summary of the focuses of the activity for the Division of Addiction Sciences?

A. That was the original four pillars.

Q. And you're the Associate Director of that division, as we've discussed; correct?

A. Correct.

Q. If you look at Page 34 of the document, at the bottom of the page it says that the, the Division of Addiction

Sciences has been established to address the scourge of substance use disorder that's affecting our community, the region, and the nation.

Do you see that?

A. I do.

Q. And is that a correct statement of what the Division of Addiction Sciences was intended to do?

A. I believe so.

Q. And, in particular, the Division of Addiction Sciences is focused on opioid abuse and OUD in the local community; is that right?

A. We use opioid use.

Q. Opioid use. Okay. So you don't use the phrase OUD?

A. We would use opioid use or opioid use disorder.

Q. Okay. So not opioid abuse?

A. Correct.

Q. That's the point you're taking issue with?

A. We don't use the term "abuse."

Q. Fair enough. So I'll use OUD. Is that, is that the right terminology?

A. Yes.

Q. Okay. And if you look at, at the bottom of 34 and over to the top of 35, it says that the department secured over 5.6 million dollars in state and external grant funding to expand services, institute new programs, and collaborate

with community partners.

Do you see that?

A. I do.

Q. And is that a true statement to your understanding, that in the first year the Division of Addiction Sciences secured 5.6 million dollars in state and external grant funding?

A. It is an accurate statement that we -- the division had secured that through June 30th, 2018.

Q. And all of those grants were then renewed in the next year; correct?

A. Not necessarily.

Q. Let me pull up, please, -- well, I'll skip that for now, Dr. O'Connell.

The division received approximately 7.1 million in grant funding for substance use programs in 2019; is that correct?

A. I'm not sure. I'd have to check.

Q. Would it refresh your recollection if I were to show you your deposition transcript from last summer where you discussed this point?

A. Sure.

Q. All right.

Could we pull up, please, the transcript, Page 65, lines 15 to 21.

There's a question that reads:

"If you had to estimate approximately how much funding you received from the Federal Government in an average year the last -- you know, this year and last year."

And your answer was, "Our department, or our division received approximately $7.1 million in external funding in FY 2019."

Do you see that?

A. I do.

Q. Does that refresh your recollection?

A. It does. And, as I said, which is estimating approximately.

Q. But that's -- that accords with your understanding that it was approximately $7.1 million in external funding?

A. For 2019.

Q. Yes. And the Division of Addiction Sciences services, the services that the division provides, are not limited to individuals in Cabell and Huntington; correct?

A. That is correct.

Q. And let me ask you a little bit more about Marshall Health just so we understand how it fits within Marshall University.

Marshall Health is the medical practice arm of Marshall University; is that right?

A. Yes.

Q. And Marshall Health, I assume, covers other health services beyond the Family Medicine services that are covered that we've already been discussing?

A. Yes. There's other departments.

Q. Can you just describe the difference between Marshall Health and Marshall Family Medicine?

A. Marshall Family Medicine sits under Marshall Health. It's a department within the practice arm of Marshall Health.

Q. What's the difference between the services provided by Marshall Family Medicine and Marshall Health?

A. It would be the same as -- Marshall University has the Department of Social Work and the Department of Health Sciences or Journalism in the same way Marshall Health would have Departments of Family Medicine and Orthopedics.

Q. And is it fair to say that the Division of Addiction Sciences is funded almost exclusively from grants and from funding from Marshall Health?

A. It is funded almost exclusively from grants.

Q. And also it receives funding from Marshall Health?

A. It is funded almost exclusively by grants.

Q. Okay. Let me show you another document if I could.

MR. HESTER: May I approach, Your Honor?

THE COURT: Yes.

BY MR. HESTER:

Q. Dr. O'Connell, we've handed you a document marked Defendants' West Virginia 2653. On its face it says "The City of Solutions, Huntington, West Virginia."

Have you seen this document before?

A. Yes.

Q. And, and you're familiar with this?

A. Quite.

Q. You were involved in the preparation of it; correct?

A. Correct.

Q. And this report was, in fact, put together by the Division of Addiction Sciences; is that correct?

A. Correct.

Q. And it was prepared for the Cabell and Huntington community; correct?

A. It was prepared as a retrospective analysis of programs that were working in the City of Huntington and Cabell County.

Q. And it was -- was it prepared at the request of the City of Huntington or Cabell County?

A. No.

Q. It was prepared by the Division of Addiction Sciences and then provided to the city and the county?

A. It was prepared by the Division of Addiction Sciences and provided to the public.

Q. And there's a, there's a Forward I'd like to point you

to at Page 7. Actually, I'll follow my convention. I'm going to work off of the little numbers at the bottom left, so .5 of the document if you follow those small numbers at the bottom left. And there's a Forward here written by Mayor Steve Williams. Do you see that?

A. I do.

Q. And I take it you're familiar with this Forward that Mayor Williams wrote?

A. I am.

Q. And was Mayor Williams involved in reviewing this report after it was finished?

A. Mayor Williams was provided a copy of the report.

Q. And is it your understanding that he reviewed the contents before writing this Forward?

A. I'm not sure.

Q. I, I assume that you were aware that he was including this Forward in the document as it was published; is that right?

A. Yes.

Q. And at the end of the Forward he states, "We're proud to have become known as a City of Solutions."

Do you see that?

A. I do.

Q. And that was part of the nature of this title of this document; correct?

MR. HESTER: Your Honor, at this time I would move Defendants' 2653 into evidence as a statement that a party manifested that it adopted.

THE COURT: Any objection?

MS. QUEZON: I don't believe so, Your Honor. Just to clarify, the entire document, City of Solutions, is being moved in?

MR. HESTER: Yes, Your Honor.

MS. QUEZON: No objection whatsoever.

THE COURT: Okay. It's admitted.

BY MR. HESTER:

Q. Let me point you first to Pages 9-10 of this document. At the bottom of the page using those small numbers at the bottom left, it says, "Recognizing the vast need for more addiction services and research early on --"

A. Sorry. I'm not keeping up with the tiny numbers versus big numbers.

MS. QUEZON: I'm not either.

MR. HESTER: Well, if you -- it's Page 11 in the document.

THE WITNESS: Perfect.

MR. HESTER: If you look at those production numbers at the bottom, it's Page 9. Sorry for the confusion on the numbers.

MS. QUEZON: I've got it.

THE WITNESS: Thank you.

BY MR. HESTER:

Q. Do you see where it says, "Recognizing the vast need for more addiction services and research early on, Marshall Health established a Division of Addiction Sciences to begin to develop and implement the programs and projects that would address all of the concerns and priorities established in the conceptualization phase."

Do you see that?

A. I do.

Q. And is that an accurate statement?

A. I believe so.

Q. And then the next sentence says, "This department continues to grow to address the growing needs of the community and currently employs nearly 30 individuals working to support community solutions."

Do you see that?

A. I do.

Q. And is that also a correct statement?

A. I would argue that the word should be "division" instead of "department," but we've used them interchangeably.

Q. So if we call it division, you would agree with the statement in that sentence?

A. Yes.

Q. And, so, this report lists many of the programs that have been put in place to deal with OUD issues in Cabell and Huntington; correct?

A. Correct.

Q. And that was the purpose of the report?

A. To demonstrate what programs were working and what programs were not.

Q. And, and Marshall was -- and remains involved in the implementation of these programs; correct?

A. Not all programs designated in the City of Solutions are Marshall programs.

Q. Many of them are?

A. Some of them are.

Q. And the Division of Addiction Sciences continues to assist with the number of these programs that are listed in the City of Solutions?

A. Correct.

Q. And many of these programs focus on the treatment of substance use disorder; correct?

A. Correct.

Q. And I'd like to talk in more detail about a number of these treatment programs now, Dr. O'Connell.

I'm going to go to the board.

So, Dr. O'Connell, I'm just going to list up here on

the board some of these treatment programs so that we have common ground. One of the perils of being left-handed is trying to write on a board I will say, one of the many perils.

During your testimony previously when you were here, Dr. O'Connell, you spoke about a program called PROACT; is that right?

A. Yes.

Q. And that was included -- that was one of the programs you highlighted in the slides that you did; right?

A. Correct.

Q. And PROACT stands for Physician Organization for Addiction Care and Treatment; is that right?

A. Provider Response Organization for Addiction Care and Treatment.

Q. Say that again.

A. Provider Response Organization for Addiction Care and Treatment.

Q. Okay.

A. I believe "provider" and "physician" have -- it may have started with "physician" and moved to "provider" to be more inclusive.

Q. And let me -- so we'll put PROACT up on the board. PROACT is a treatment program; correct?

A. Correct.

Q. And let me show you another document.

MR. HESTER: May I approach, Your Honor?

THE COURT: Yes.

BY MR. HESTER:

Q. Dr. O'Connell, we've handed you a document marked Defendant's Exhibit 1352. At the top of the page it says "Marshall University Joan C. Edwards School of Medicine Major Initiatives in Response to the State's SUD Crisis."

Have you seen this document before?

A. I think so.

Q. And this is, this is a document that summarizes a number of programs undertaken by the Marshall University School of Medicine; correct?

A. All except one. The Neonatal Treatment Unit is housed at Cabell-Huntington Hospital, but it's supported by Marshall Health physicians.

Q. And the rest of these programs that are listed here you would view as Marshall University programs?

A. No. They would be viewed as Joan C. Edward's School of Medicine slash Marshall Health Program.

Q. Okay. This -- the organization -- I'll try to keep up with you on this. But --

A. You and everybody else. It is confusing.

Q. So -- but the programs listed here are ones that are

run by the Marshall University School of Medicine with the exception of the Neonatal Therapeutic Unit; correct?

A. The -- it is accurate to state that any program we work on is under the umbrella of Marshall University. However, just specifically, we identify as the umbrella of the Joan C. Edward's School of Medicine which is the medical school for Marshall University.

Q. Let me point you to the second sentence of the document. And it's referring here again to the Division of Addiction Sciences where you work; correct?

A. Correct.

Q. And it says in the second sentence, "The division has rapidly grown in the past three years in leading comprehensive, coordinated efforts to respond to substance use at local community and regional levels." Is that right?

A. Correct.

Q. And I wanted to ask you there -- first of all, is that a true statement?

A. We rapidly grew in the first three years of the division, and our goal is to respond in a coordinated fashion.

Q. To substance use at the local community and regional levels; correct?

A. Correct.

Q. So you would view that as a true statement?

A. I believe so.

Q. And is there an effort to coordinate efforts at the regional level to think about some of these substance use programs across a wider geography than simply an individual city or an individual county?

A. Yes.

Q. And what are the benefits of doing that looking across a region?

A. Substance use is not isolated into any singular city or county.

Q. So there's an effort to look at solutions to substance use that cut across many counties or across a region; correct?

A. Our goal is to help save lives, whether they reside as our neighbor or across town.

Q. And is it also fair to say that there are efficiencies from looking across a broader geography and thinking about how you would handle a substance use program or treatment program?

A. There are both strengths and weaknesses to that perspective.

Q. Let me go halfway down the page and focus you on the discussion of PROACT.

PROACT -- and it states that PROACT was opened in 2018 through the collaboration of Marshall Health, Valley Health,

Cabell-Huntington Hospital, St. Mary's Medical Center, and Thomas Health. Do you see that?

A. I do.

Q. Is that a true statement?

A. That is.

Q. And those organizations all operate in the Cabell/Huntington community; correct?

A. At the time of conception, those were the five organizations. There are now four organizations and three of which provide treatment in Cabell County.

Q. And none of those -- and the three organizations that are now running PROACT are which ones?

A. So Thomas Health was included, although they're in Charleston, with the hopes of expansion to Charleston. So Thomas Health does not provide services.

Valley Health, the federally qualified healthcare center, SQHC, is no longer operating at PROACT.

Q. So the three that are operating at PROACT now are Marshall Health, Cabell-Huntington Hospital, and St. Mary's Medical Center; is that right?

A. Correct.

Q. And none of those are run by -- none of those three organizations are run by Cabell County or the City of Huntington; correct?

A. Correct.

Q. And it states that PROACT is a coordinated effort of the medical community to provide comprehensive assessment, education, intervention, and treatment in a single accessible service hub to adults suffering from substance use disorder.

That's a true statement; correct?

A. Correct.

Q. And it says that PROACT provides services that include clinical assessments, medication-assisted treatment, peer recovery supports, individual and group therapy, spiritual support, career placement, and career readiness training.

Do you see that?

A. Yes.

Q. Is that a true statement?

A. Yes.

Q. And PROACT provides all those services?

A. Under the roof of PROACT, all those services are offered.

Q. And, so, PROACT, it's fair to say, is a program for outpatient management of people suffering from substance use disorder of various types; correct?

A. Correct.

Q. And that's going to include people who have a substance use disorder based on opioid use; correct?

A. Correct.

Q. So PROACT provides treatment services for those with OUD in the Cabell/Huntington community; correct?

A. Correct.

Q. And it is fair to say that PROACT provides a full range of addiction treatment services for people with OUD; correct?

A. We're working towards a comprehensive intake and treatment provision.

Q. And that includes clinical assessments of people with OUD; correct?

A. That would be the ASAM, the American Society of Addiction Medicine, intake on that continuum of care that we talked about on the first day.

Q. And that would also include what's called medication-assisted treatment or MAT; correct?

A. Based on the intake, some individuals may be identified that they could benefit from being on medication to assist them coming off of other drugs. Some individuals may choose medication-based treatment and others may not. So MAT is one of the treatments offered.

Q. And just explain what MAT is.

A. Medication-assisted treatment most commonly includes treatment such as their brand name being Suboxone, which is a sublingual strip that an individual puts under their tongue daily.

If it does not have the, the blocker, which is Naltrexone, in it, then it's called Subutex. And that's often given to pregnant women. However, the guidelines just changed for that. Or it could include Vivitrol which is the shot that's administered monthly.

And they have had, I believe, one or two patients get the new injectable which goes under the skin and is a slow release form of Subutex.

Q. And, so -- and PROACT provides all of those three forms of treatment?

A. PROACT predominantly provides Subutex or Suboxone to individuals who are choosing the MAT pathway.

Q. PROACT also provides peer recovery support?

A. Correct.

Q. Provides individual and group therapy; correct?

A. Correct.

Q. Spiritual support?

A. Correct.

Q. It provides career placement and career readiness training?

A. And that's done through the final category on the sheet, CORE.

Q. Okay. So let's, let's make sure we've got these other categories.

So listed on the same sheet is a program called CORE

and we'll come back to that. But that CORE is a program run by the Marshall University School of Medicine that provides career placement and career readiness training?

A. Among other things, yes.

Q. And, so, I take it that these -- this range of services we've just gone through are meant to be a comprehensive menu of treatment options for people with OUD; correct?

A. Yes. We would -- some individuals may choose MAT pathways. So they may choose a medication-based recovery. Other individuals may choose abstinence or a non-medicated recovery. And, so, there are different options there for folks.

Q. And PROACT, I take it, is affiliated with Marshall Health; correct?

A. Correct. Our physicians are some of the providers within PROACT. PROACT has its own governing board, so they're a little bit different. But they count as the employees of the Division of Addiction Sciences.

Q. And, so -- yeah, so, that was my next question actually. Is it part -- is PROACT part of the Division of Addiction Sciences?

A. Yes.

Q. And PROACT is not run by the city or the county; correct?

A. Correct.

Q. All right. I'm going to put that on the board.

When I said city or county there, Dr. O'Connell, I meant City of Huntington or Cabell County. Is that how you understood it too? It's not run by the City of Huntington.

A. It's not run by.

Q. The City of Huntington or Cabell County; --

A. Correct.

Q. -- correct?

Let me show you another document.

MR. HESTER: May I approach, Your Honor?

THE COURT: Yes, you may.

THE WITNESS: Thank you.

BY MR. HESTER:

Q. Dr. O'Connell, I've handed you a document that's marked P-41051. It's headed on the first page -- it appears to be an email from Tina Ramirez dated 12/19/2018 and attaches a Director's Report to it.

Dr. O'Connell, I take it you've received this document; correct?

A. Correct.

Q. And your email -- you received it in the email that's listed from the note from Tina Ramirez; right? It's about halfway through.

A. Correct, yep.

Q. And this is discussing PROACT; correct?

A. Correct.

Q. So you, you received this email?

A. Yes.

Q. Do you remember seeing it?

A. No, but I did receive this email back in 2018.

Q. And Tina Ramirez is the Director of the Great Rivers Regional System of Addiction Care at Marshall Health; correct?

A. Correct. Tina reports to me.

Q. All right. So she, she directs the Great Rivers Regional System Program?

A. Addiction Care, yes.

Q. Yes. And that's one of the, one of the programs that's listed on the prior page that we were looking at, Defendant's Exhibit 1352; correct?

A. It is.

Q. And she includes an attachment which is a Director's Report for PROACT. I assume you've seen this. Correct?

A. I've seen most of the Director's Reports for PROACT, yes.

Q. And the Director's Report is published each year; correct?

A. Quarterly.

Q. Quarterly you think?

A. I think so. I'm not involved in the preparation of

this document.

Q. But you receive it in your role as the Associate Director of the Division of Addiction Sciences; correct?

A. Correct, and we share it widely which is why it's on this email.

Q. Do you share it widely with the community or only within -- is it an internal document?

A. This would indicate that it was shared with people who are in the Great Rivers Regional System of Addiction Care. That's who I believe this email listed.

Q. And this terminology of Great Rivers, I know it refers to some of the great rivers in West Virginia. But what, what area are you talking about when you refer to the Great Rivers?

A. For this specific project, when it was written it was Cabell, Cabell County, Putnam County, Kanawha County, and Jackson County.

Q. And, so, there's an effort to think about those counties as a region when you're thinking about some of these addiction treatment services?

A. I did not write that grant, but the implementation was to coordinate existing programs across those four counties where there's a QRT -- a Quick Response Team in one county. If there was a Quick Response Team in another county, they should be sharing what works and what doesn't work.

Q. So the effort is to look at, at some of the programs and to run some of the programs across a four-county region?

A. Not necessary to run, purely to coordinate to say if Cabell County has a successful Quick Response Team, how are they doing documentation? So Cabell County's person, through Great Rivers, got with Jackson County's person or Kanawha County and they talked about what program successes they had.

Q. So let's look at Page 6 of this Director's Report, please. And I wanted to point you to the top of the page.

A. Which tiny number is that?

Q. The tiny number -- now we're at the bottom right tiny number.

A. Yes.

Q. Do you see that Number 6?

A. Six.

Q. Sorry for the multiplicity of numbers, but it's the bottom number at the right-hand corner.

A. 00006.

Q. And do you see there's a table at the top of the page, and it says, "The majority of our intakes continue to request referral for MAT services, mostly Suboxone through [sic] 11 requested Vivatrol."

Do you see that?

A. I do.

Q. I'm sorry. "Though 11 requested Vivitrol." I misread that. Do you see that?

A. I do.

Q. And does that accord with your understanding that the majority of your -- of the intakes for PROACT when the program began were requesting referral for MAT services?

A. I believe the Director's Report.

Q. And it indicates, if you look over to the next page, that PROACT provided MAT treatment to 57 individuals in October, 2018. Do you see that?

A. Yes.

Q. And does that accord with your understanding?

A. I believe the Director's Report.

Q. And to be clear, when PROACT provides MAT treatment, it's providing that regardless of whether someone is abusing a prescription opioid or an illegal drug such as heroin; correct?

A. The medications Suboxone and Vivitrol are most commonly provided for an individual using -- who's trying to come off opioids.

Q. And, so, that could include an individual who's trying to come off of heroin; correct?

A. Correct.

Q. And it could include an individual who's been abusing prescription opioids; correct?

A. Correct. Vivitrol can also be used for alcohol withdrawal.

Q. And, so, so Vivitrol, which is one of the ones requested there, is that also used for OUD treatment?

A. Yes, can be.

Q. Now, a number of, of people receiving treatment through PROACT are -- have substance abuse issues involving non-opioids; correct?

A. Individuals can seek treatment at PROACT for any substance use disorder.

Q. So that could run a wide gamut from alcohol to methamphetamine to cocaine to heroin?

A. Correct.

Q. It could be a very wide range; right?

Now, it indicates -- if you look at the bottom of Page 7, there's a table there that indicates that 122 people receiving treatment were abusing heroin. Do you see that?

A. I do.

Q. And that's far more than any other category, including prescription opioids; correct?

A. Correct.

Q. And does that accord with your understanding that the, that the vast majority of individuals seeking treatment in PROACT were abusing heroin?

A. I believe the Director's Report.

Q. So let me show you another Director's Report which you'll probably also agree with.

MR. HESTER: May I approach, Your Honor?

BY MR. HESTER:

Q. So, Dr. O'Connell, we've handed you what's been marked as MC-West Virginia-2136. On its face it appears to be the PROACT Director's Report dated May 8th, 2019. Have you seen this document before, Dr. O'Connell?

A. I'm sure I have.

Q. And you would have received this, again, in your role as Associate Director of the Division of Addiction Sciences; correct?

A. Correct.

Q. Let's turn to the fifth page of this document and again look at the numbers at the very bottom.

And, so, this list -- this table at the bottom of the page lists the various alternative forms of treatment being provided for people with substance use disorder; correct?

A. Correct.

Q. And that's going to include people who have opioid use disorder who are going to PROACT; correct?

A. Correct.

Q. And if we look at this listing, it lists abstinence as one form of treatment; correct? That just means withdrawing entirely from the drug; correct?

A. Most likely that's how they're defining that, that they're not using any form of pharmaceutical intervention for substance use.

Q. And the next treatment listed is IOP. What does that stand for?

A. Intensive outpatient. So it is a -- on that continuum of care, it follows at the higher range but not residential.

Q. So intensive outpatient would mean what? Could you describe roughly what it is?

A. Based on, based on the criteria from the ASAM assessment, the American Society of Addiction Medicine assessment, an individual may fall in the higher levels of a two-point intervention.

So if they're in the threes, they're being referred to residential. If they're below that and it's not just going to therapy once a week or once a month, intensive outpatient normally involves at least daily interventions. But they're not residing at the location of those interventions.

Q. So for somebody who's in intensive outpatient, how often would they get treated a week?

A. It would vary from almost, sometimes four to eight hours a day every day to maybe two hours three times a week.

Q. And, in contrast, if somebody's just in outpatient care, how often would they get seen?

A. An individual could go to outpatient care daily as

well, but maybe meet with a therapist one hour a week. For MAT treatment that would be considered outpatient in most cases.

Some individuals in residential care are also on MAT. But if they were just outpatient, it involves one hour of therapy monthly and eight hours of group therapy monthly, and then one hour of physician engagement across that time span, or two hours monthly of that can be broken down in different categories.

Q. And if somebody is taking MAT in addition to that outpatient care, do they just stop by and get the medicine and then go on about their business or --

A. No.

Q. They have to get that by going to, to a treatment?

A. There are very strict guidelines around the provision of MAT services and what other support services need to be provided to an individual.

So if you're on medication-assisted treatment, you're also -- you need to meet with your prescribing physician weekly. You need to be meeting in group therapy weekly. And you would receive some form of one-on-one individual therapy. Sometimes they do it 30 minutes weekly or one hour weekly or one hour every two weeks.

Q. And, and PROACT is providing all those services; correct?

A. Correct.
Q. And, so, just so we have the record clear, the -- this treatment type listing shows abstinence at 62 individuals; correct?
A. Correct.
Q. It shows one person in intensive outpatient; correct?
A. They're very hard to get in and maintain any type of job or -- so it's much rarer.
Q. It's rare that people want to do intensive outpatient?
A. It's a narrow window where you would maybe be better served by residential. And your need is so high that you need to be in that much -- that high a level of care. But to be in that high level of care and maintain anything with child care or a job would be very challenging.
Q. The next, the next treatment type listed is mental health. One person listed for that; correct?
A. Correct.
Q. And that's, again, a service -- a mental health service that PROACT provides?
A. I believe that's probably just an individual seeking therapy with no other supportive services. And their mental health may be the primary diagnosis and/or a no-longer-remaining substance use disorder diagnosis.
Q. Okay. The next one over -- I'll skip a couple of these others. But then there's two listed for residential. Does

that mean somebody who's in inpatient care?

A. So it means that PROACT referred an individual to -- and the same would be true of IOP. The intake happens and they refer the individual to intensive outpatient or refer the individual to residential treatment.

Q. So some other, some other facility actually provides that treatment?

A. Yes.

Q. And then there's a reference -- we see 461 being treated with Suboxone. So that's a form of MAT; correct?

A. Correct.

Q. And, so, by far, the predominant form of treatment reflected here was the MAT; correct?

A. Correct.

Q. And then Vivitrol, that's the other one you had mentioned which can be used for alcohol abuse but also could be used for OUD; correct?

A. It's the injectable. So it's injected whereas Suboxone is taken daily.

THE COURT: Mr. Hester, my apologies, but I've got to interrupt you so we can switch out court reporters.

MR. HESTER: Sure, Your Honor.

THE COURT: I've got to accommodate Judge Berger. So we'll be in recess for about 10 minutes.

MR. HESTER: How long, Your Honor?

THE COURT: Ten minutes.

MR. HESTER: About 10? Okay, sure.

(Recess taken at 9:55 a.m.)

THE COURT: Whenever you're ready, Mr. Hester.

MR. HESTER: All right. Thank you, Your Honor.

BY MR. HESTER:

Q. Dr. O'Connell, it's fair to say that many, if not most of PROACT's treatment services, are covered by health insurance, correct?

A. I do not know the percentage of served versus underserved.

Q. Let me ask you to look at Page 7 of the document, this one we were just looking at, which is MC-2136 and this has a page that's headed "Payer Mix." Do you see that?

A. I do.

Q. And maybe I could ask you a top-level question first. You understand that the treatment services provided by PROACT, many of them are subjected to reimbursement by insurance, correct?

A. Medication assisted treatment is subject to reimbursement.

Q. And also inpatient and outpatient treatments are subject to reimbursement, correct?

A. Those would be intensive outpatient, IOP, and residential would be referred to other organizations, not

provided at PROACT.

Q. Those are also subject to reimbursement when they're referred, correct?

A. They can be, yes.

Q. And here, if we look at Page 7, there's a payer mix and it -- this first sentence leads the payer mix for patients has been primarily West Virginia Medicaid 67% percent. Do you see that?

A. I do.

Q. Does it accord with your understanding that roughly 67% of the patients served by PROACT are paid for by Medicaid?

A. I believe the director's report.

Q. And does it also accord with your understanding where it goes on to say private insurance is the next most common payer with 12%, followed by self-paid; do you see that?

A. I do.

Q. So, does that accord with your understanding, as well, that private insurance makes up the next largest share of payers for the services at PROACT?

A. I believe the director's report.

Q. And it also states in the next sentence that Medicare made up 7% of the payer mix and Kentucky and Ohio Medicaid were at 1% and 3% respectively. And I take it you agree with those numbers, too?

A. I do.

Q. Dr. O'Connell, is it fair to say that PROACT has the capacity to treat about 700 people with substance use disorder at any one time?

A. I am not sure.

Q. If I were to show you a document that -- could I refresh your recollection on what the number is?

A. That would be great.

Q. Let me --

MR. HESTER: May I approach, Your Honor?

THE COURT: Yes.

THE WITNESS: Thank you.

BY MR. HESTER:

Q. Dr. O'Connell, we've handed you a document that is marked Defendants' Exhibit 3555. It appears to be an article, a newspaper article, dated May 21, 2019. Have you seen this document before, Dr. O'Connell?

A. One moment. I have never read this document in full, but I have seen it. I recall Dr. Petrany being interviewed and so, I was trying to find him.

Q. There's a photograph of Dr. Petrany on Page 10, correct?

A. There is.

Q. He's your boss, correct?

A. He is.

Q. And over on Page 9, this is the only reference I wanted

to show you in the document. In the next to the last paragraph on that page, it says -- it refers to the mayor. I take it that's Mayor Williams, correct?

A. I believe so.

Q. And it refers to PROACT here and it says that there's a new initiative called -- called a provider response organization for addiction care and treatment, or PROACT, and then it goes on in the next sentence to say that the clinic has capacity of 700. Do you see that?

A. I do.

Q. Does that accord with your understanding?

A. So, capacity would change based on the number of treatment providers we have. So, I can say that the capacity is currently less than that based on the number of prescribing physicians due to the three organizations, not four, currently providing treatment.

Q. Was this where the capacity was in 2019, to your recollection?

A. I have no reason to dispute this number, but I can't -- I can't say from my other than experience or knowledge of the providers that were currently there.

Q. Dr. O'Connell, as of March, 2020, when your deposition was taken, is it correct that PROACT had seen at least 1,800 individuals for treatment?

A. Did I state that in my deposition?

Q. I can -- I could show you if you want. I just wanted to ask if that accorded with your memory, that it had seen about 1,800 people for treatment since -- as of March, 2020?

A. I recall trying to do the math quickly. And so, if that was my identified number at the time, I'd stand by it.

Q. Well, I don't want you to guess. Do you want me to show you the transcript? Would that help you?

A. Sure. I haven't actually seen my deposition.

Q. Why don't we pull that up, please. It's transcript Page 182, Lines 13 to 20. And the question, you were asked is approximately how many individuals is PROACT currently treating. And then your answer was, they have done 1,800 intakes since opening, I believe. So, does that accord with your understanding, 1800 intakes since PROACT had opened?

A. Correct. And I do go on to ask for clarification between treating and intakes because those are two different things.

Q. Right. That's fair. So -- so, there might be an intake and some of the intakes might be referred to some other facility, correct?

A. We have people who come in for an intake and never return. They come in and they don't follow through with any care. We have individuals who have an intake and are seen at PROACT. And individuals who have an intake and are referred elsewhere.

Q. Do you know roughly how many people PROACT has treated since it's opened?

A. I do not.

Q. It's -- would it be somewhere in the range of 1,800 people?

A. Their current case load I believe to be just a little above 500 currently.

Q. And that's 500 people being currently treated by PROACT?

A. I believe so.

Q. And then cumulatively over time would that suggest roughly, what, 2,000 people since PROACT opened?

A. I'm not sure. I just know their current census.

Q. The number that you gave here of 1,800 intakes since opening, that's referring from -- from PROACT's opening in the Fall of 2018 to March, 2020, correct?

A. Until -- when was my deposition?

Q. March, 2020.

A. Then yes.

Q. Okay. And that seems right to you? That number sounds right?

A. I would have had a reason for stating it at the time. I haven't been in their census in quite sometime.

Q. Let me ask you to look at another document, please.

MR. HESTER: May I approach, Your Honor?

THE COURT: Yes.

THE WITNESS: Thank you.

MR. HESTER: And, Your Honor, before we go on, I would like to move into evidence the two director's reports that we've discussed. One is MC-2136 and the other is Plaintiffs' Exhibit 41051. These are two director's reports that we've discussed with Dr. O'Connell.

THE COURT: Is there any objection to either of those?

MS. QUEZON: No, Your Honor.

THE COURT: They're both admitted.

By MR. HESTER:

Q. All right. Dr. O'Connell, we've shown you another document. It's labeled MCWV-2139. It's headed on the first page "Pro-active Executive Summary". Have you seen this document before, Dr. O'Connell?

A. I'm not sure.

Q. Do you believe you would have received this in your role as Associate Director of Addiction Sciences?

A. Do you have a date for this document?

Q. I can point you to Page 4 and, again, using the page, the small numbers at the bottom, if you look at the heading for outcomes, it refers to PROACT's first year of operation. So, it would have been sometime after the Fall of 2019 that this would have been prepared, correct? I'm trying to

figure out whether you would have received this.
A. I'm trying to see if it's part of the -- because an Executive Summary would have only been compiled -- I'm just trying to get a date on it so I kind of know when it was. My version of this is clickable, so -- oh, okay.
Q. Do you believe you received this document?
A. I am not sure. I cannot recall when I would have received it, but as with other documentation with PROACT, I often am included.
Q. Okay. Let me ask you to look just at Page 4, please. At the top of the page there's a heading for outcomes. Do you see that?
A. Yes.
Q. And it says in the first sentence, in the first year of operation, PROACT saw over 1,000 unique individuals for assessment by program clinicians and referred to an appropriate level of care. Do you see that?
A. Yep.
Q. Does that accord with your understanding as to roughly how many individuals PROACT saw in its first year of operations?
A. I have no doubt. I have no reason to doubt this.
Q. And it goes on in the next sentence to say, of the individuals assessed, so of that group of 1,000, almost 70% were retained as patients at PROACT. Do you see that?

A. I do.

Q. And does that also accord with your understanding that roughly 70% or roughly 700 people would have been retained as patients at PROACT in the first year of operation?

A. I have no reason to doubt this.

Q. And it also says that 86% of those retained, so that would be 86% of the 70%; is that right?

A. Yes.

Q. Were identified as appropriate for MAT services. Does that accord with your understanding?

A. I have no reason to doubt it.

Q. So, roughly speaking, about 560 people would have been treated for MAT services by PROACT in the first year of operation, correct?

A. Percentages were never my forte', but I'll take your word for the 86% of the --

Q. I'm multiplying seven by eight.

A. Okay.

Q. Roughly, it's 560 or so, correct?

A. Okay.

Q. And it would have been roughly 700 people treated as patients by PROACT in the first year, correct?

A. Correct.

Q. And then it goes on in the final sentence of that paragraph, PROACT currently has a 52% patient retention rate

following 90 days of treatment date. Does that mean how many people continue to be treated by PROACT after 90 days; is that what it's referring to?

A. Within the realm of addiction treatment tracking out 90 days for medication based treatment and identifying the number of patients who were seen for an intake and then are continuing to be seen at 90 days is a benchmark and this would indicate that 52% of those initially seen were still being seen at 90 days.

Q. And I take it some of the people who are not retained by PROACT might have resolved their issue within 90 days, correct? In other words --

A. Highly unlikely.

Q. And so -- so, the retention rate is what, measuring people who don't continue to choose to come back?

A. As with any treatment of a Substance Use Disorder, the first time is not successful for many individuals. On average, we say that it takes nine times to quit smoking. So, if it's taking an individual on average nine times to quit smoking, we know that abstaining and stopping opioid use and finding a life of what we define as long-term recovery often takes individuals many attempts. So, they may start at PROACT and they may unfortunately end up incarcerated because they identify fines or warrants that are out for their arrest.

We would have individuals who come once, twice, three times, don't come back. They go back to using. And we have some who may need, you know, a higher level of care. And so, they're seen and then referred out to another service.

For medication assisted treatment, the standard is that an individual should receive treatment for no less than one year. So, the majority, I would say almost all individuals, would not have resolved their Substance Use Disorder within 90 days. You do, however, have the same way with anything, people who smoke for 30 years and quit one day and never look back.

Q. So, some people might resolve in 90 days, but you're saying not -- that's not -- you don't view that as the norm?

A. I wouldn't -- if I had to guess, I'd say maybe one individual has had that sort of intervention and resolution.

Q. And do you typically see that after a year people have resolved?

A. Medication assisted treatment providing and prescribing is something not my expertise, but some individuals need to be on medication assisted treatment for a year; others, five years; others, it may be a lifetime in the same way that with -- as we look at other chronic diseases like asthma and hypertension, we see those have a -- what we call a recurrence of symptomatology in the same way that substance use disorders have a recurrence of symptomatology, but if

you can work on maintenance, you can find that people can enter a life of long-term recovery.

Q. And you can, in fact, see after a year's time people are able to get back to a life?

A. For some individuals, a year is just -- we don't have a lot of long-term research in that we weren't providing medication assisted treatment 25 years ago. So, we don't know if it takes 25 years because it wasn't being provided at the -- in the way it is now. So, we know from our initial guidelines from SAMHSA is that medication assisted treatment should be provided for at least a year to see what we define as efficacy in a program or effectiveness.

Q. And the -- the technology is also changing. You mentioned some of the medicated assisted treatment is now like a -- for instance, a shot that might be once a month, correct?

A. There are different types of medication assisted treatment on the market. However, they vary widely in compliance, and effectiveness, and also reimbursement, whether we can get -- we can't get anybody to get Sublocade covered, for example, right now.

Q. But medicated assisted treatment that PROACT provides is subject to reimbursement by insurance, correct?

A. Currently, Suboxone and Subutex are often able to be reimbursed through a process of receiving -- the MCL

language --

Q. The either Medicaid or private insurance, correct?

A. Yes. In some cases, those can be reimbursed.

Q. In most cases, correct?

A. In most cases, there is a reimbursement structure.

Q. For medicated assisted treatment?

A. For some forms of medication assisted treatment.

Q. Let me ask you to look back at the City of Solutions document. And I'm going to toggle back and forth a little bit with the City of Solutions document. If you look, do you have that one there, Dr. O'Connell?

A. One moment. Sorry. Got it.

Q. And if you look at the City of Solutions document, which -- which again is -- for the record, is Defendants' Exhibit 2653, I wanted to point you to Page 62, again, using the small numbers at the bottom. And this is a summary of PROACT, right? Do you see that?

A. Yes.

Q. And the first sentence I wanted to ask you about, it says PROACT required $1.3 million in renovation costs of a building to set it up, correct?

A. Correct.

Q. Is that your -- is that consistent with your understanding?

A. It is.

Q. And then, if you go a few sentences further down, it says initial funding of $1,000,000.00 per year from Cabell Huntington Hospital and St. Mary's Medical Center for PROACT was received for the first five years. Do you see that?

A. I do.

Q. So, does that reflect that the funding for PROACT was a million dollars a year from Cabell-Huntington Hospital and St. Mary's Medical Center together? They were giving a million dollars each year to fund PROACT?

A. I believed it to be $400,000.00, so I would like to check that.

Q. You believed it to be $400,000.00? Well, is that -- could that be $400,000.00 from each, accounting for the million?

A. Well, that would account for $800,000.00.

Q. Well --

A. My percentages aren't great, but I do add. That may be the case, but that's -- I'm trying to -- the hospitals -- to open PROACT, as there was no grant funding to support PROACT, committed to -- they were tired of seeing individuals in their Emergency Department and on the floors of the hospital that they weren't -- that they deemed recurrent visitors or frequent fliers. And so, to offset those costs, the hospitals engaged in the setup and foundation of PROACT.

Q. And is --

A. I assume -- I have no doubt, reason to doubt this, but I thought it was $400,000.00 from each of them.

Q. So, if it was $400,000.00 from each of them, it would be $800,000.00 in total that they committed over a five-year period?

A. Uh-huh.

Q. And that's your understanding of what the funding was?

A. Yes.

Q. And the hospitals viewed this as a form of cost savings because they were able to set up PROACT as an alternative so they didn't have as many of these folks coming into their hospitals on a regular basis, correct?

A. I don't know if they perceived it as cost savings but, rather, they were seeing a patient population that they were unable to treat and we required some sort of treatment and they believe in healthcare and treatment. And so, that was how PROACT was established.

Q. All right. Let me show you another document.

MR. HESTER: May I approach, Your Honor?

BY MR. HESTER:

Q. Dr. O'Connell, we've given you a document marked as DEF-WV Exhibit 03 -- no, sorry -- 03542, Defendants' Exhibit 03542. It's -- the first page says, "Produced in native format", which is just a mechanical point about how

it was produced. And then, there's a spreadsheet underneath. Dr. O'Connell, I take it you're familiar with this spreadsheet, right?

A. Generally, yes.

Q. And this is a spreadsheet of the finances for the Division of Addiction Sciences, right?

A. It is.

Q. And this was prepared by people with knowledge of the activities that are reflected here?

A. Yes.

Q. And it's kept in the course of regularly conducted activity within the division, correct?

A. Correct.

Q. And making budgetary records like this is a regular practice of the division?

A. All of our grants have to be accounted for. So, these are cost centers where invoices are sent to.

MR. HESTER: So, Your Honor, I would move for admission of this document as a business record.

THE COURT: Is there any objection?

MS. QUEZON: I'm not going to object to hearsay. I'm not sure about relevance, but I'm sure Mr. Hester will --

THE COURT: Well, I'm going to admit it.

MS. QUEZON: -- clear that up.

THE COURT: I think Mr. Hester has laid a foundation for it. It's admitted.

BY MR. HESTER:

Q. So, I wanted to --

MR. ACKERMAN: Your Honor, I apologize. If I may, the bottom of this document, it appears, has some hash tags.

THE WITNESS: The number is too small -- or too large for the column designation.

MR. ACKERMAN: Yeah. That's my -- that's my concern, is that I just want to make sure the document is accurate. I noticed that the Excel spreadsheet came on and that's what flagged this issue for me.

So, for instance, if you look at the third column down here, the third column of numbers under administration, there's total surplus. And it's got pound signs there. And I don't know what it says on the actual native document.

If you can pull it up, it appears that it just didn't print correctly. So, I just wanted to note that for the record.

MR. HESTER: Well, if there's a problem, we can substitute another version of this, Your Honor.

THE COURT: Well, okay.

MR. HESTER: I -- I only have a few questions about a few numbers on this, but if there's a problem, we can substitute another one.

BY MR. HESTER:

Q. Dr. O'Connell, I wanted to ask you about the column for PROACT. There's some entries you can see at the top for PROACT and this is where you said this is a -- there's a program that the Division of Addiction Sciences oversees and so, you keep the finances for PROACT, correct?

A. Correct.

Q. And it reflects that in 2020, the total revenue for PROACT was $823,216.00, correct?

A. Yes.

Q. And if you look at the column that says PROACT for 2020 total surplus deficit, excluding grant funding, it was $168,000.00, correct, down at the very bottom? If you look at the very bottom, you'll see --

A. Yes. Mine has the pound sign. Sorry.

Q. Yours has the pound sign?

A. Doesn't it?

Q. I'm holding one that doesn't. I can show you this one, if you wish, Dr. O'Connell. Do you see -- and let me -- let me point you to the screen. Do you see on the screen, Dr. O'Connell, there's a number $168,644?

A. Yes.

Q. And so, that -- that shows -- that's the net. That's the revenue less the expenses and it shows expenses for PROACT of $991,860, correct?

A. That, it does.

Q. And so, the -- so, the deficit for 2020 was $168,000.00 for PROACT, correct?

A. I don't -- I am not responsible for our financial structure of both budgeting, or this document, or any of the accounting for it. So, I cannot speak to when these numbers indicate in the fiscal year, whether that's a remaining advancement or deficit, in that our financial year does not end in May, 2020. So, I know that much.

MR. ACKERMAN: And, Your Honor, I just want to note for the record that there's a number that's highlighted on the screen that doesn't appear on the piece of paper that's handed out to everybody. So, this is the issue that I flagged.

MR. HESTER: I can give you mine that has it, if you want to see it. If you want --

MR. ACKERMAN: I trust what's on the screen. I'm just saying that --

MR. HESTER: I mean, I may not -- I'm telling -- there may be a mechanical point with the printing.

MR. ACKERMAN: Yeah.

MR. HESTER: I don't think there's a doubt that that's what it says because I'm holding it in my hand.

THE COURT: The one that I have also has the pounds at the bottom rather than the numbers. So, make sure

the one that gets in the record has the numbers in it.

MR. HESTER: I apologize, Your Honor. I don't know if you've ever had the joy of working with Excel. It's dreadful. And I try to avoid it whenever I can.

MR. FARRELL: Judge, just to give my colleague an assist, that's what happens when you -- the print program tries to squeeze --

THE WITNESS: To one page.

MR. FARRELL: The Excel spreadsheet down onto the paper. If it exceeds the column, it goes "XXXXX".

MR. HESTER: Mr. Farrell, thank you.

Thank you, Your Honor.

THE COURT: I'm going to trust counsel to get the right copy in the official record.

MR. HESTER: Okay.

BY MR. HESTER:

Q. So -- so, Dr. O'Connell, all I really wanted to establish is that when we look at this document we can see a revenue line and we can see an expense line for PROACT as of the date it was prepared for 2020, correct?

A. Correct.

Q. So then, if we can go back to the City of Solutions document again. And, again, if you can look at Page 38. No, it's 68. I'm sorry.

A. In the tiny numbers?

Q. 62. Sorry, Dr. O'Connell. My apologies. 62 in the little numbers.

A. Yeah.

Q. The last sentence of that discussion of PROACT says the long-term goal is to make all of the services billable. Do you see that?

A. I do.

Q. And that's referring to the long-term goal for PROACT to make all of the services it provides billable; true?

A. That is our goal.

Q. And it would be billable to insurance; is that correct?

A. The -- with any of our programs we do not open a program that we are not willing to commit to sustain. So, whether that means it breaks even or has a deficit, that it sits within a larger organization that's committed to the philosophy of that program.

With the medical services we provide we expect them to be reimbursable. With efforts around certified peer recovery coaching, we expect that to be reimbursable. Workforce development will never be reimbursable. There is no structure currently in place or even theoreticized in place for that.

Q. Well, but when you say that the long-term goal is to make the services billable, is that -- is that services billable to whom, to insurance?

A. Correct.

Q. And so, the long-term goal is to make PROACT self-sustaining, correct?

A. Our goal is to not run a deficit on PROACT.

Q. But the other point you made is that Marshall has committed to support these programs it's running even if some of them run a deficit, correct?

A. Our goal is to not start something we're not willing to continue.

Q. And that would apply to all the programs that Marshall has started?

A. That would apply to our treatment services. I would say it would apply to PROACT and Project Hope for women and children.

Q. And PROACT does not receive any funding from the City of Huntington or Cabell County, correct?

A. Correct.

Q. Let me ask you to now -- we're going to switch to another program, another treatment program. In your slides you had referred to a program called Maternal Addiction Recovery Center, correct?

A. Correct.

Q. And that's sometimes abbreviated as MARC?

A. Correct.

MR. HESTER: Can you get this board back up?

BY MR. HESTER:

Q. And that's another -- that's another form of treatment program, Dr. O'Connell?

A. That is not through the Division of Addiction Sciences.

Q. But it's -- but it's -- it's a treatment program in the community, correct?

A. It is a program run by Marshall Health OB/GYN, obstetrics and gynecology for pregnant women who are currently struggling from Substance Use Disorder.

Q. So, it would be -- it would be a treatment or a maternal support system for women who have Substance Use Disorder and who are pregnant; is that correct?

A. For women who have Opioid Use Disorder. It is an entirely MAT-based program. So, women who are identified as being pregnant and needing services who are going through Marshall OB/GYN are offered treatment in the MARC program, which would include weekly individual, group and medication assisted treatment, along with the high risk assessment necessary to monitor a woman who is -- is or was using substances while pregnant.

Q. Let me ask you to turn back again to the City of Solutions document, Exhibit 2653, and if you could look at Page 40, and using the small numbers, there's a description of MARC. Do you see that?

A. Yes.

Q. And I think this confirms what you've said but let me just make sure. If you look a few sentences down under that heading for MARC, it says, the MARC program provides specialized comprehensive care for women with high risk pregnancies. Do you see that?

A. Yes.

Q. And it's referring to women with high risk pregnancies who have OUD?

A. Correct.

Q. Let's turn back to -- let's look at Page 59 of the City of Solutions document. This -- this summarizes a number of these programs, correct?

A. Correct.

Q. And you can see that MARC is on there three from the bottom, correct?

A. Correct.

Q. And then over the on the right-hand side, there's a column for individuals served and it says moderate. Do you see that?

A. Yes.

Q. And if you turn over the page, there's -- there's a heading for individuals served and it's defined in the City of Solutions document as high, can serve hundreds to thousands of individuals across the entire community. Moderate can serve up to hundreds of individuals in specific

circumstances. And low can serve a small, very specific group of individuals. Do you see that?

A. Yes.

Q. And -- and does that -- does that accord with your understanding of what was being done here on Page -- if we look back then on Page 59 where it lists the individuals served, it's using those definitions of either high, moderate or low?

A. Yes.

Q. And so, if we look at MARC, it says moderate, which means it has a capacity to serve up to hundreds of individuals in specific circumstances in the community; is that right?

A. I would disagree with that designation, but that is what it states.

Q. What's your understanding of the capacity for MARC?

A. They only have one prescribing physician, so it -- it's based on that, which means that a singular prescribing physician who has gone through credentialing and certain time frames of training in medication assisted treatment can build their caseload from less than 20 to over a hundred. So, that means any singular prescribing physician can work to have a caseload of over a hundred. That is limited by the number of therapists and group. MARC runs normally three groups, which are capped at 12 people.

Q. So, but you're saying any individual treating physician could be running a capacity up to about a hundred; is that right?

A. Based on training, credentialing and time framing of MAT history, they can eventually have a larger caseload that is subjective of -- that's subject to the limitations of the mental health providing, as well. So, you have to have -- you can only have 12 people in a therapeutic group if you're going it bill. So, you cannot have 13 or 14 people. You can only have 12. So, although a provider could have a hundred people, they have one therapist, they're limited to the number of groups that therapist could run to the number of people they could provide treatment to.

Q. The cost associated with this MARC program are covered by most health insurers and by Medicaid, correct?

A. The medication assisted treatment component would be covered.

Q. And the other costs, as well, right?

A. I'm not sure. And I do not know MARC's standing budget.

Q. Let me ask you to look at another document.

MR. HESTER: May I approach, Your Honor?

THE COURT: Yes.

THE WITNESS: Thank you. Oh, I got two.

MR. HESTER: Oh, you have two?

THE WITNESS: You're used to giving me big documents.

BY MR. HESTER:

Q. Dr. O'Connell, we've handed you a document marked as MCWV-2119. This appears to be a printout from a website for Marshall Health dealing with MARC. Have you seen this before?

A. I believe this is their website.

Q. And I just wanted to ask you one piece about this. If you look over on the second page of the document, please.

A. Yep.

Q. And there's a second bullet that says costs associated with the program are covered by most health insurances and Medicaid programs in the Tri-State area. Do you see that?

A. I do.

Q. Does that accord with your understanding?

A. I assume. That's their report.

Q. And you have no reason to doubt that?

A. No.

Q. The MARC program that we've been discussing is not run by the City of Huntington or Cabell County, correct?

A. Correct.

Q. And the City and the County don't provide any funding to the MARC program, correct?

A. I do not believe so.

Q. Let's go to the next program. Your slides also summarize something called the Maternal Opioid Medical Support Program, right?

A. Correct.

Q. And that's referred to as MOMS?

A. Yes.

Q. Fantastic use of acronyms, I would say, Dr. O'Connell.

A. I cannot take credit for any of the current acronyms.

Q. So, let's look at Page 43 of the City of Solutions document, please.

MS. QUEZON: I'm sorry, Mr. Hester, the page again?

MR. HESTER: 43.

THE WITNESS: Teeny tiny 41.

MR. HESTER: No, I'm sorry. For the small numbers, 41. Sorry.

BY MR. HESTER:

Q. And this is where it's discussing the MOMS program, correct?

A. Yes.

Q. And it says that -- at the top it says that MOMS was developed to provide substance abuse disorder recovery support for both postpartum women and their babies and to provide it in a convenient location, correct?

A. Substance Abuse Disorder recovery support, yes.

Q. And so, that would include support for babies born with NAS, correct?

A. No. They operate in conjunction with the Neonatal Treatment Unit, but they are -- they are providing services to the MOMS.

Q. Okay. So this is providing a service to a mother who has delivered a baby with NAS?

A. Correct.

Q. And so, what kind of services are being provided? Are these treatment services being provided?

A. MOMS is not my program. It is run by Cabell-Huntington Hospital. However, they provide where the MARC -- the easiest way for me to think about it is where the MARC program drops off, MOMS picks up. So, if you were pregnant and you had a child who was then born with exposure of some kind the MOMS program would then work with you in the hospital or if you were -- had a child born with exposure and you were not previously in a program, MOMS could sort of pick you up and work with you while your child is being treated in the NTU.

Q. And if you look down to the third paragraph on this page, the third sentence, it reads the nurse practitioner in collaboration with the physician provides medication services included but not limited to Buprenorphine, Naloxone, et cetera. And so, this is a form of treatment

provided to mothers who've delivered babies with NAS?
A. Women in the program are offered medication assisted treatment.
Q. And if you look at Page 59 again in the City of Solutions document, again, I'm going back to this discussion on capacity we were having previously and it lists MOMS as moderate, which is defined as can serve up to hundreds of individuals. Do you see that?
A. I do.
Q. And is that consistent with your understanding?
A. I believe it's going to be the same capacity in that although there may be a treatment providing -- treatment provider who has a larger medication assisted treatment capacity, the limitation is those supplemental services.
Q. Supplemental services provided by a doctor?
A. The mental health services that are being provided, the individual and treatment capacity. To my knowledge, MOMS normally, at its peak, I think, had a census of approximately 60.
Q. 60 people being served?
A. Yes.
Q. And that would be 60 people who are -- have recently given birth to a baby with NAS?
A. Recently given birth to a child with exposure.
Q. Exposure to --

A. To a substance. So, not all infants are diagnosed with Neonatal Abstinence Syndrome.

Q. But it could be mothers who have given birth to a baby with any kind of substance abuse, not just opioid abuse?

A. Because this is a medication assisted treatment program, it's going to be predominantly far and away opioid use because Suboxone, and Vivitrol, and Subutex are all used to treatment opioid use disorders only.

Q. And so, that would include, for instance, mothers who were using heroin during their pregnancy, gave birth to a baby, and then still having heroin problems after giving birth, correct?

A. It could include a woman who was using a substance, opioid based, and then has an infant born with some level of exposure or withdrawal symptoms that has them identified and detected and then served by the Neonatal Treatment Unit because that's different than the NICU, which is just the Neonatal Intensive Care Unit. They're separate.

Q. Yeah. And I wanted to clarify, that would include heroin abusers who have given birth to a baby, correct?

A. It would include individuals who have used heroin.

Q. The MOMS program is part of the Hoops Family Children's Hospital at Cabell Huntington Hospital; is that right?

A. Correct.

Q. And it's funded through grants and donations; is that

correct?

A. I do not know.

Q. MOMS is also billed to Medicaid; is that right?

A. I assume they are billing their medication assisted treatment services.

Q. And the MOMS program is not run by Cabell County or the City of Huntington, correct?

A. No, it is not.

Q. And the MOMS program does not receive funding from Cabell County or the City of Huntington, correct?

A. I do not believe so.

Q. Let me ask you to turn to another program. In your slides you had discussed Prestera; is that right?

A. Yes.

Q. And Prestera offers a variety of treatment programs, including detoxification and stabilization; is that right?

A. Prestera has historically provided withdrawal management or detox. I do not currently know their detox management services.

Q. And is it serving a community focused on OUD or is it focused more broadly on substance use disorders?

A. Prestera is one of the long -- or one of the oldest sort of community-based mental health and substance use treatment centers.

Q. So, it's surely be treating people with OUD, correct?

A. I would assume so.

Q. And it focuses on the Cabell-Huntington community?

A. I don't know their captured area.

Q. But it includes Cabell-Huntington?

A. It would.

Q. And Prestera offers outpatient treatment as well?

A. I believe so.

Q. And does it offer residential treatment?

A. In the City of Huntington?

Q. Or Cabell County?

A. Not for all populations.

Q. For some populations with OUD, it offers residential services?

A. I believe they have a men's treatment center.

Q. So it treats men with OUD, but not women?

A. Their women's based program is in Charleston.

Q. Okay. So, their men's based program is based in Huntington?

A. I believe so. I do not have the interworking of Prestera, so --

Q. Prestera also offers medication assisted treatment; is that right?

A. They do.

Q. So, they're another treatment program we should list, right?

A. Yes.

Q. Prestera has three locations in Cabell County and one location in Wayne County; is that right?

A. I don't know their location in Wayne.

Q. Do you know they have three locations in Cabell County?

A. They have two locations on Route 60. I'm trying to think of where their third location is.

Q. Route 60 is in Cabell County?

A. It is.

Q. Let me show you a document, please.

MR. HESTER: May I approach, Your Honor?

THE COURT: Yes.

THE WITNESS: Thank you.

BY MR. HESTER:

Q. Dr. O'Connell, I've shown you a document marked MCWV-2167. It's a printout of the Prestera website. Have you seen the Prestera website?

A. I know that it exists.

Q. Let me -- I have just a simple question, I think, for you. It states that -- in the first sentence, Prestera Center impacts over 20,000 adults, children and families across West Virginia each year and has been helping people lead happier, more fulfilling lives since 1967. Do you see that?

A. I do.

Q. Does that accord with your understanding that Prestera serves about 20,000 people across West Virginia each year?

A. I have no reason to doubt their website.

Q. And do you have any understanding as to how many people Prestera serves in Cabell County and Huntington?

A. I have no idea.

Q. I take it it would be thousands of people in Cabell County and Huntington?

A. I have no idea.

Q. They have three centers there. Do you think they would be serving a population of thousands or --

A. I truly don't know.

Q. Do you have an understanding that Prestera bills Medicaid and other insurance for the services it provides?

A. I believe so.

Q. And Prestera is not run by the City of Huntington or by Cabell County; is that right?

A. It is not.

Q. And it does not receive funding from the City or the County, correct?

A. I do not know.

Q. But it's not run by the City or the County?

A. It is not.

Q. Let me ask you about Lily's Place. This was another treatment center and treatment service that your slides

discussed previously; is that right?

A. Yes.

Q. Let me ask you again, maybe just to set the table here, Lily's Place provides service -- treatment services for babies born with NAS and their mothers; is that right?

A. Lily's Place is unique in that it's the first non-hospital based neonatal abstinence treatment center.

Q. So, it's treating babies born with --

A. Infants born with exposure.

Q. And when we say "exposure", you mean infants born with NAS?

A. Infants born with exposure to substances.

Q. And that would include infants with exposure to opioids; is that correct?

A. It would.

Q. So, that's another treatment sort of program we should list?

A. It's a treatment program for infants in the same way that the Neonatal Treatment Unit at Cabell Huntington Hospital is. It's just an outside-of-hospital-based setting.

Q. And if you look at the -- well, I think maybe I can ask you this broadly. Do you have an understanding of the capacity that Lily's Place can serve?

A. They have less than ten nursery rooms.

Q. And that's based in the City of Huntington; is that right, Lily's Place?

A. It is.

Q. Do they have other facilities outside of the City of Huntington?

A. They do not.

Q. Lily's Place treats infants with NAS who are born to mothers who live outside of Cabell and Huntington, correct?

A. They -- they may treat individuals -- yes. They would have individuals who delivered at Cabell-Huntington or another hospital and chose treatment for their infant at Lily's Place.

Q. And is it fair to say that a number of the babies who are born in the hospitals in the City of Huntington might be from the broader region outside of Cabell County and Huntington?

A. Yes.

Q. So, it would be fair to say, as well, that then a substantial proportion of the babies born with NAS might be born to mothers who live outside of Cabell and Huntington?

A. I cannot speak to whether it's substantial or an equal proportion.

Q. You don't know what percentage it is, whether it's 10%, or 90%, or 50% born to mothers who live outside of Cabell-Huntington?

A. I do not know. However, Lily's Place is not able to serve those outside of the state.

Q. So, Lily's Place can only serve babies who are born to mothers who live somewhere in West Virginia; is that right?

A. I believe so.

Q. And Lily's Place is a non-profit organization; correct?

A. They are.

Q. And it's not affiliated with the City of Huntington or Cabell County, correct?

A. It is not.

Q. And it's not run by the City of Huntington or Cabell County?

A. It is not.

Q. And Lily's Place is not funded by the City of Huntington or Cabell County, correct?

A. They are not.

Q. And the services that Lily's Place provides are subject to reimbursement by insurance, correct?

A. Some.

Q. And Lily's Place also receives funding from the State of West Virginia, correct?

A. I believe they receive grant funding as a large number of their services originally were not covered by any insurance.

Q. And then, over time, more of their services are

provided -- are paid for by insurance?

A. I don't currently know their status, but they had to pursue legislative changes to receive any type of reimbursement because they were a non-hospital based medical center.

Q. You mentioned before that Lily's Place could only serve babies born to mothers who live in West Virginia. Is that because the State of West Virginia is providing funding for it?

A. I'm not sure.

Q. Let me ask you about Project Hope. Your slides discussed Project Hope; is that right?

A. Yes.

Q. You've been personally involved with Project Hope, correct?

A. Yes.

Q. And at a high level, Project Hope provides treatment and housing for women with Substance Abuse Disorders and their children; is that right?

A. Substance Use Disorders, yes.

Q. And that would include women who have Opioid Use Disorders, correct?

A. It would.

Q. If we look at the City of Solutions document, Exhibit 2653, I wanted to point you to Page 38.

A. Or tiny font 36?

Q. Oh, you're way ahead of me. It's, yes, 36 at the bottom. Thank you. And at the bottom of the first paragraph it says that Project Hope is under Marshall Health's License Behavioral Center, Behavioral Health Center, and provides services at the ASAM 3.5 level. Do you see that?

A. Yes.

Q. So that's for people with relatively more severe diagnoses; is that right?

A. To meet criteria for residential treatment you have to be unable to thrive in the community.

Q. And that's what ASAM 3.5 means?

A. The American Society of Addiction Medicine 3.5 criteria has a whole host of objectives that must be met to submit for authorization of that level of care.

Q. And so, Project Hope is providing 24-hour residential inpatient services for mothers with Substance Use Disorders, correct?

A. Correct.

Q. And it can house 17 families at any one time; is that correct?

A. 16, but yes. It was 17. We altered an apartment status to 16.

Q. And so, in the first year, Project Hope housed 12

families at one point and the most it housed during the first year was 14; is that right?

A. That is correct.

Q. And so, when we talk about families there, we're talking about a mother with a new baby; is that correct?

A. We have initially established seven two-bedrooms and 11 three-bedrooms. And so, Mom may have had existing children or had twins. And so, it would include Mom -- to meet criteria, Mom has to be either pregnant or parenting a child and currently experiencing a Substance Use Disorder.

Q. And does the baby have to be born with NAS --

A. No.

Q. -- to meet the criteria? It's really focused on the mother?

A. It's focused on the family unit.

Q. And so, you could -- the point you're making is you could have the mother there with other children including the newborn?

A. We often do.

Q. And Marshall Health is responsible for the oversight and therapeutic services of Project Hope; is that right?

A. We are the Medical Director and we do offer -- the services are provided through Marshall Health and Marshall Family Medicine. Some do continue to see a pre-existing treatment provider.

MR. HESTER: So, let me pass out now -- Your Honor, I think we now have happily a new version of this document, Defendants' Exhibit 03542 that resolves the "XXX" that we had before on that. So, may I approach?

THE COURT: Yes.

MR. HESTER: For the record, I believe this document was introduced into evidence, Your Honor, and we were going to fix it so that it printed more properly.

BY MR. HESTER:

Q. And I think this one is correct, Dr. O'Connell. This one now has numbers at the bottom of the page.

A. I appreciate that. Thank you.

Q. Okay. And I wanted to ask you now about the column for Project Hope. Do you see on this -- on this spreadsheet there's a column shown for Project Hope?

A. I do.

Q. And it reflects that the funding for Project Hope comes from patient collections and contractual medical fees. Do you see that?

A. Yes.

Q. When it says contractual medical fees, there's a line entry there for Project Hope contractual medical fees. Does that mean medical fees being provided by Project Hope? I'm sorry, medical services being provided by Project Hope under some sort of treatment contract?

A. I am not sure what is designated by that category.

Q. But it reflects that the total revenue for Project Hope that's shown for 2020 is $1.63 million, correct?

A. Again, I just -- I want to hold discrepancy to the idea that it's 2020 in that the document was dated May, which is not the end of our fiscal year.

Q. Well, you could have a document prepared in May that would recap the number of fiscal years, correct?

A. But it doesn't include the 2020 fiscal year and I just know that because what the grant income is annually remains the same in that we have a five-year SAMHSA grant, Substance Abuse and Mental Health Administration grant, and the grant amount should be the same annually and this is only reflecting a small portion of that grant income. So, for 2020, it's not accurate in that -- a fiscal year. It seems to be maybe a quarter.

Q. So, your point is that the 2020 numbers that we're looking at here might be for less than a full year?

A. I'd almost guarantee it.

Q. Probably are less than a full year, but if we look at the 2020 for whatever period, would your estimation be that it's for the first quarter of 2020?

A. I'm not sure what the estimation is.

Q. Can you eyeball it by seeing the difference in the grant income between 2019 and 2020?

A. Seems to be less than a quarter than.

Q. And so, but for whatever period of time covered here for 2020, it shows total revenue of $1.6 million; is that right, for Project Hope?

A. To that cost center, yes.

Q. And it shows total expenses for Project Hope for the same time period of $616,000.00, correct?

A. Correct.

Q. And it shows a total surplus, excluding grant funding for that same time period, that was a surplus of $655,000.00; is that correct?

A. Considering Project Hope has yet to break even, I'm aware that there's inaccuracies in that.

Q. I'm asking you what it shows here.

A. It shows in that line $6,555 -- 700 --798.

Q. It's not 6,655.00.

A. $655,798. Sorry.

Q. So, that's -- so, it's showing here a surplus for Project Hope, correct?

A. Whatever date this was compiled, yes, to that cost center.

Q. When we look at the -- for that same period of time for 2020, it shows patient collections of $989,000.00 for Project Hope. Do you see that?

A. I do.

Q. And so, that means those are patient collections coming from billing to Medicaid and other insurance, correct?

A. Yeah. That's the total -- I believe what's designated on here is that's indicating the total collections for the existence of Project Hope and we did not receive anything for the first year. It took a very long time to receive finances for it.

Q. But I was trying to get to the source of the collections. When we talk about collections here, that's reflecting reimbursements coming from insurance for the treatment services being provided by Project Hope; is that right?

A. That is often how we denote collections, so I assume that that's what's denoted here.

Q. And most of the payments that are shown is patient collections that would be coming from insurance reimbursement, correct?

A. Correct.

Q. Project Hope is not run by the City of Huntington or by Cabell County, correct?

A. Correct.

Q. And Project Hope does not receive any funding from the City of Huntington or Cabell County, correct?

A. Correct.

Q. We forgot to put this on the board.

A. We abbreviate it PHWC, if that helps.

Q. I won't remember that.

A. Project Hope for Women & Children is lengthy.

Q. Let me go on to another program that Marshall is involved in, another treatment program. I believe it's a treatment program I want to ask you about, Recovery Point?

A. Not involved.

Q. Let me ask you to look -- do you know about Recovery Point? You know it exists?

A. Yes.

Q. Let me ask you to look at Page 47 of the City of Solutions document.

A. Do you mean 45?

Q. Yes, I do. Sorry. Page 45 on the small numbers. And there's -- in the second paragraph, there's a reference to Recovery Point. Do you see that?

A. I do.

Q. And it says Recovery Point is a six-location facility across West Virginia with headquarters and original facility located in the heart of the City of Huntington. Does that accord with your understanding?

A. Yes.

Q. And it says Recovery Point has been a leader in expanding Peer Recovery services through the community. Do you see that?

A. Yes.

Q. And is that what it focuses on, is peer recovery services?

A. So, in that the other programs we've discussed are physician or mental health led, Recovery Point West Virginia is based purely on peer services. So, as individuals move through the program and graduate, they then take on leadership roles within the organization. And so, almost all individuals working for the organization are individuals in long-term recovery themselves who almost always went through Recovery Point or a similar peer based program.

Q. And so, then they are -- they have gotten through the program or have gotten to a certain point of recovery and then they're assisting new people who are coming into the program who need help dealing with OUD or other Substance Use Disorders?

A. Correct.

Q. And -- and that's been a successful program, correct?

A. They -- they report success in that model.

Q. And if you look at Page 64 of the City of Solutions document, it says Recovery Point does not charge individuals for their stay and operates mostly off of annual and ongoing fundraising and grants. Do you see that? Sorry. You're not caught up to me yet.

A. Nope. Went back to the tiny ones. Yes. Recovery

Point had -- does not receive any reimbursement for their services.

Q. And they serve -- is it correct that the next sentence says the facility serves 110 participants at a time? Does that accord with your understanding?

A. It does.

Q. And let me ask you to look at another document, please.

MR. HESTER: May I approach, Your Honor?

THE WITNESS: Thank you.

BY MR. HESTER:

Q. Dr. O'Connell, we've shown you a document marked MCWV-2130. It's a printout from the Recovery Point website. Have you seen Recovery Point's website before?

A. I have been on it, yes.

Q. Let me ask you just one question about it. There's a -- at Page 3 of the document, there's a final paragraph that says Recovery Point West Virginia's long-term recovery program alumni maintain a 68% sobriety rate one year after graduating the program. Do you see that?

A. I do.

Q. Does that accord with your understanding?

A. I have not seen their data.

Q. Do you have any reason to disagree with that?

A. When we talk about efficacy, when we mentioned PROACT, you said at 90 days it was -- you know, of the initial

intakes, 70% remained. Of those, 56, I think, or above 50% were retained at 90 days. So, retention rate at 90 days is a significant benchmark in that people drop out in those 90 days at a much higher rate than they do the longer you have them.

So, an individual receiving on -- or an individual receiving care is likely to start and stop and start and stop until they stabilize. And once they're stabilized, they're believed to have a -- you're just going to have more success. So, people drop out early. And then, once they're sort of in and they're working through stuff, they're more likely to sustain.

So, with the PROACT benchmark, we were measuring at 90 days because we -- our goal is to improve that retention rate. It's not the same to compare that number to one year following graduation. So, I just think it's important that we -- anytime I'm measuring efficacy, those are two different conversations.

Q. Yeah. And I wasn't purporting to put that together with the prior one.

A. Okay.

Q. I was really just asking you about this one-year figure that's cited here.

A. They're reporting that individuals who complete their program, which is at least a year program, they're

indicating that 68% of those, that they have graduated, continue to maintain sobriety.

Q. And do you have any reason to doubt that?

A. I have -- I have not seen their data, but I have no reason to doubt their website.

Q. And Recovery Point is not run by the City of Huntington or by Cabell County, correct?

A. It is not.

Q. And it's not funded by the City of Huntington or Cabell County, correct?

A. I don't believe so.

Q. Just a couple more, but I'm running out of real estate on my board.

A. I see that.

Q. Your slides also discussed Project Engage; is that right?

A. Yep. Yes.

Q. Let's turn to Page 15 of the City of Solutions document, please, 13 under the small numbers.

A. What was the small number?

Q. 13.

A. 13?

Q. Do you have that?

A. Yes.

Q. Do you have that one, Dr. O'Connell?

A. I have it, yes. Thank you.

Q. Okay. And there's a second sentence in the second paragraph that says an initiative called Project Engage was developed to screen all patients admitted into the hospital for Substance Use Disorder and provide specific care to those with such needs. Do you see that?

A. I do.

Q. Is that consistent with your understanding of what Project Engage does?

A. It is what we hoped Project Engage would do.

Q. And are you saying it doesn't do that?

A. I am.

Q. Do you see there's a statement down in the bullets? It refers to rapid treatment of withdrawal by a medical team. Does Project Engage do that?

A. Christiana Health Care's approach does that.

Q. And is Project Engage associated with Christiana Healthcare?

A. They came in and demonstrated their model, which is where the term "Project Engage" came from.

Q. And does Project Engage still exist?

A. Yes and no.

Q. Your slides discuss them.

A. Yeah.

Q. I'm confused.

A. When we discussed them, I had indicated it had changed over time to the bridging the gap, the mosaic model.

Q. The mosaic model?

A. Uh-huh. That was the last one with the --

Q. And is it a form -- does Project Engage provide treatment services?

A. The goal was that Cabell Huntington Hospital and St. Mary's would have addiction specialists who were screening individuals who were coming through -- who had been admitted to the hospital and were there often for endocranitis or other health concerns. And then it was identified that they have a substance -- it was identified they had an existing Substance Use Disorder.

At that time, this has ebbed and flowed in that one of the addiction specialists left the hospital. It took quite sometime to replace them. St. Mary's moved forward in a different, much more structured policy format; whereas Cabell moved forward with peers. So, it exists in different formats across the two.

Q. Is it -- Project Engage essentially is part then of programs provided by these hospitals?

A. Yes.

Q. And Project Engage is not run by the City of Cabell -- or the City of Huntington or Cabell County, correct?

A. It is not.

Q. It's not funded by Cabell County or the City of Huntington?

A. It is not.

Q. I have one more to ask you about, one more program, I think, which is the Great Rivers Regional System for Addiction Care that you discussed in your slides. Marshall has a leadership role in the Great Rivers Regional System for Addiction Care; is that right?

A. The grant runs through us.

Q. And the objective of that program is to focus on treatment programs across the region; is that right?

A. The goal of that grant is coordination, to bring together the six objective areas of the grant, to coordinate them through meetings and engagement. It provides no services or treatment.

Q. So, Great Rivers is a -- somewhat of an umbrella organization that's helping with --

A. Coalition.

Q. And it's --

A. It's not even --

COURT REPORTER: I'm sorry. Can you finish the question? I couldn't --

MR. HESTER: Sorry.

BY MR. HESTER:

Q. It's helping with the administration of programs across

the region; is that fair to say?

A. It is a coalition. So, it's a group of individuals across four counties that meet together to discuss and overcome roadblocks and hurdles, but it does not provide any direct services or treatment.

MR. HESTER: May I approach, Your Honor?

THE WITNESS: Thank you, sir.

BY MR. HESTER:

Q. Dr. O'Connell, I've handed you a document marked MCWV-2135. It's headed "Great Rivers Regional System for Addiction Care 2019-22 Strategic Plan".

A. Yes.

Q. I take it you've seen this document before?

A. I have.

Q. And you were involved in the preparation of the document?

A. My team was in the preparation of the document.

Q. And your name is listed as -- as an acknowledgment on the second page; is that right?

A. Correct.

Q. And the document was -- is prepared by this coalition, this Great Rivers Regional System Coalition; is that right?

A. Correct.

Q. And is this a document that was prepared by persons with knowledge of the activities of Great Rivers Regional

System?

A. I believe the document is compiled by our Director of the grant and the external evaluator.

Q. And it was prepared by Tina Ramirez; is that right?

A. Yes.

Q. And you said she works for you?

A. She does.

Q. And does she regularly prepare these plans for the Great Rivers Regional System for Addiction Care?

A. This was a singular plan in compliance with the grant.

Q. Oh, I see. So, this was -- this was a document that had to be put together for purposes of the grant?

A. Correct.

Q. And this was a grant that was received from MERCK; is that right?

A. MERCK Foundation is the funder of this project.

Q. Right.

MR. HESTER: Your Honor, I would move this into evidence.

THE COURT: Any objection to 2135?

MS. QUEZON: No, Judge.

THE COURT: It's admitted.

BY MR. HESTER:

Q. So, let me ask you to look in this document, Dr. O'Connell, at Page 26. This is where it lists different

components for a -- an effective opioid response plan, is that right?

A. These are the six components that Great Rivers chose to target at the request of the MERCK Foundation.

Q. So, just so I'm clear on this, so these were the pieces that Great Rivers had targeted as the constituent elements for an effective opioid response plan; is that fair?

A. These are the six pillars of the -- of the grant that they're seeking to coordinate across the four counties. So, they were -- PROACT, as being a highly innovative model, was detected by the MERCK Foundation and the others are all similarly unique. And so there -- the goal was to coordinate and collaborate across those six areas.

Q. And it reflects here on Page 26, as we're looking at it, that these components are found -- all six of these component elements are found in Cabell County; is that right?

A. Yes.

Q. And that's what the X's denote in that column?

A. As of February 21st, 2019.

Q. And if you look over on the next page, Page 27, there's a table that shows about four or five rows down that says number of MAT providers office-based, do you see that?

A. Yes.

Q. And it shows that there are 14 facilities providing MAT

services in Cabell County; is that right?

A. I see that, yes.

Q. More than any other -- more than the other three counties except for Kanawha, right?

A. Correct.

Q. Let me ask you to look at Pages 28-29 and there's a discussion on Page 28 right in the paragraph in the middle of the page that refers to a system called CAST, Calculating For an Adequate System Tool, and an evidence-based tool developed by the Centers for Disease Control and Prevention and the Substance Abuse and Mental Health Services Administration, SAMHSA. Those are two federal government organizations, right?

A. They are.

Q. And are you familiar with this tool called CAST?

A. I had never used it before this.

Q. But you learned about it in connection with developing this plan?

A. Yes.

Q. And over on the next page, it says that CAST projects there are 178,000 substance users within the Great Rivers Region, of which 24,389 are opioid users. Do you see that?

A. I do.

Q. Does that -- is that confined to people who have Opioid Use Disorder? When it refers to 24,389 opioid users, does

it include people who misuse opioids but maybe do not have Opioid Use Disorder? Do you understand what I mean?

A. Are you asking if there's a distinction between opioid misuse and Opioid Use Disorder?

Q. Yes.

A. It's a highly subjective area for discussion in that Opioid Use Disorder would be the formalized medical diagnosis provided. However, many individuals with Opioid Use Disorder are not being seen by a provider and have not been diagnosed with that.

Q. But there can also be people who misuse opioids who do not have Opioid Use Disorder, correct?

A. If you're taking more of your prescribed medication than is prescribed, you may have opioid misuse or dependency and may be on the verge or have an existing Opioid Use Disorder that you're not aware of until you attempt to stop that medication because withdrawal and tolerance are two of the diagnostic criteria.

Q. But you also might misuse opioids without having an Opioid Use Disorder at all, right?

A. I don't know if I can answer that in -- in sort of medical expertise, but in our work with folks, if you're misusing your opioid, you have an Opioid Use Disorder.

Q. So, somebody who takes one more pill than they're prescribed, you would consider them to have an Opioid Use

Disorder?

A. I cannot diagnose that.

Q. So, I -- what I wanted to clarify here is when it says 24,389 are opioid users, do you construe that to mean people who have Opioid Use Disorder?

A. I do.

Q. Okay. And then it says 6,341 of those opioid users are individuals seeking treatment. Do you see that? It's the next sentence.

A. Yes.

Q. And so, that means of that, that group of people, roughly 25,000 or 24,000 people with Opioid Use Disorder, about a quarter of them are actually seeking treatment; is that correct?

A. Based on the CAST data at that time, yes.

Q. And these numbers are for the entire Great Rivers Region?

A. That is what it indicates.

Q. And it reflects the total population covered here, 364,000 people. Do you see that?

A. Yes.

Q. And do you know in Cabell County and the City of Huntington, roughly speaking, there's about 90,000 people?

A. I believe so.

Q. So -- so that that means, roughly speaking, Cabell

County is about 25% of the population of this Great Rivers Region, correct?

A. The only area larger is Kanawha County. So, Kanawha County being the largest in the state; Cabell County being second; and then Putnam and Jackson being less.

Q. It's really 360 divided by 90,000. About 25%, right?

A. Right.

Q. Does that sound right?

A. Yes.

Q. And then we just talked about the fact that the estimate here from the CAST data is that 6,300 people are opioid users seeking treatment, correct, across the entire Great Rivers Region?

A. Correct.

Q. So, if Cabell County holds 25% of the population of that region, you expect about 1,500 opioid users would be seeking treatment who reside in Cabell County or City of Huntington, right?

MR. ACKERMAN: Objection, Your Honor.

THE COURT: What's the basis?

MR. ACKERMAN: Foundation. And are we just reading out of this document or --

THE COURT: Overruled.

MR. ACKERMAN: Okay.

THE WITNESS: Can you repeat the question?

BY MR. HESTER:

Q. Yeah, sorry. So, just to make sure that we've got the logic right, we've established that Cabell County, City of Huntington, accounts for about 25% of the population of this Great Rivers Region that was being looked at here, right?

A. Yes.

Q. And we've also talked previously that across this Great Rivers Region there's about 6,300 people who are people with OUD seeking treatment, correct?

A. As defined by the CAST data at that time.

Q. Right. So, that would suggest, roughly speaking, if we just apply that percentage, suggests roughly that about 1,500 people in Cabell County and the City of Huntington would be seeking treatment?

A. Based on those percentages of the CAST data, that would be accurate. Our limitation of this, which is stated both for the partner and the CAST, is that completion rates were significantly low causing a barrier to tool analysis.

Q. But if we take these CAST data as they're written here, that would be the conclusion that would be roughly speaking of a group of about 1,500 people in Cabell County, City of Huntington, seeking treatment?

A. Based on the limitations of the CAST data at that time, that's what those numbers would indicate. That's also why that data was not published, as it was not deemed to be

accurate.

Q. The CAST data is the data set developed by the federal government, by the CDC, and SAMHSA, correct?

A. The CAST is just a tool, so it's an incredibly lengthy tool that we sent out to all of the people who are part of the coalition. So, we had difficulties with completion rates. We had difficulties with the designee for the organization having all of the knowledge for that organization to complete it accurately. And we had just fatigue. People stopped completing it, as it is a burdensome tool, to be honest. It's not a survey that took someone a few minutes. So, as you can see, the categories on the following pages are just an example of some of those capacity questions.

Q. Let me ask you to look back at the City of Solutions document, please.

A. Sure.

Q. And if I could point you to Page 59 on the -- using the small numbers.

A. Yes.

Q. It lists the program for Great Rivers here. Is it suggesting that Great Rivers here is a treatment program or is it really just a coordination program?

A. Suggesting that it is what it is, which is a coordination program, as it -- that's why the category for

that is program or initiative and not treatment.

Q. So, maybe I'll -- then I need a little help from you on -- if you go to Page 62 of the document. I'm sorry. City of Solutions document. If you look at the bottom of that paragraph talking about Great Rivers Regional System, there's a final sentence that reads, in addition, with the advent of the Medicaid SUD waiver, many of the services will be reimbursed by Medicaid. Do you see that?

A. I do.

Q. And so, what services are they talking about there, treatment services?

A. So, if Great Rivers is seeking to coordinate PROACT or seeking to establish Quick Response Teams across the four communities, part of those discussions for collaboration is, Putnam County, if you set up a Quick Response Team, the goal and sustainability would hope that over time those services would be provided or Great Rivers is willing to work with you to apply for a grant.

Q. So --

A. The latter is true for Great Rivers. Great Rivers directed Putnam County Coalition members to the state when the state released a request for funding and Putnam County applied for that funding to receive a Quick Response Team.

Q. So, the services being provided by Great Rivers would be coordinating services?

A. Purely.

Q. And then those would be subject to reimbursement by Medicaid?

A. None of the services -- we will not be able to sustain Tina and her staff through reimbursable services.

Q. So, what does it mean when it says many of the services will be reimbursed by Medicaid?

A. That Great Rivers is staffed by Tina Ramirez. She is the director. So, she brings together people like Connie Priddy from the Huntington Quick Response Team and the Charleston Police Department for the Charleston -- or Kanawha County Quick Response Team.

So, a specific example would be Connie is using core data and that's how they're pulling information out of the EMS records and then collecting that info to know where and how to intervene.

Charleston was not using that data system, so we got Charleston with Connie and said Connie has figured out how to create a drop-down menu in your EMS health care system, health records system, that plugs into core data. You should do the same. Now, Charleston has a drop-down menu.

So, these little things that may -- well, they're not little. These are huge barriers to providing effective treatment that take a lot of time and energy. So, if one community has figured it out, we would like to share that

with another community. And that is the goal of Great Rivers.

So, it's not providing any direct treatment services. There are no mental health providers. There are no physicians on the grant. It's purely how do we bring together systems to communicate better.

Q. And then Great Rivers is helping people figure out ways to get reimbursement for different services through Medicaid?

A. If Putnam County -- and this literally just happened. Putnam County was agreeable to starting a Quick Response Team. So, they did not have any funding for that. So, we -- so, Great Rivers directed them to the State's RF open funding request for Quick Response Teams and that funding was pursued by Putnam County with the support of these other parties because they were then all talking. So, Cabell could say we will write a letter to say you can do this and we'll show you how. And Marshall wrote a letter and said we will help you with finding peers to go out with the Quick Response Team.

Q. So, your point is, for instance, on the Quick Response Team example, that's funded by the State, correct, different counties?

A. Cabell County does not receive state funding. They receive Bureau of Justice funding and ECI, Empowering the

Communities. The State recognized that Quick Response Teams were highly effective and designated startup funds to counties to start Quick Response Teams.

Q. And you said Cabell County receives other kinds of funding. It receives federal funding for that?

A. The Bureau of Justice is a Department of Corrections funding stream, I believe, from the federal system. Empowering Communities Initiative, I believe it's -- it might be under HRSA, the Health and Human Services. That's -- it's probably spelled out in here.

Q. But your point is the Quick Response Team is funded either by federal or state money?

A. They'll lose their funding in September of this year.

Q. But they have been funded that way?

A. The initial funds for the first three years were through those two grants.

Q. And then the State is now funding Quick Response Teams in different communities?

A. The State has provided startup funds to get Quick Response Teams off the ground and then counties had to apply for that. I believe they were $50- to $70,000.00 worth of funds.

Q. Dr. O'Connell, we've -- we're almost through this board. Are there any other treatment programs serving Cabell-Huntington that you're aware of besides the ones

we've listed here? And I mean treatment programs for Opioid Use Disorder, NAS, et cetera.

A. Yes.

Q. And which ones are those?

A. So, of those 14 MAT treatment programs identified in the partner tool, there's OVP, which is the Ohio Valley Physicians. They have an office. Huntington Behavioral Health has an office. There is a Methadone clinic that has an office.

Q. Others that occur to you?

A. Not off the top of my head. I would have to take a second and think it through. There's medication assisted treatment like a physician could provide treatment out of a primary care office. Oh, Valley Health has a treatment program.

Q. Are there others?

A. Project Engage would include Cabell-Huntington and St. Mary's, correct.

Q. So, we've got Project Engage already.

A. Of direct treatment, I can't think of --

Q. So, we've talked about OVP, Ohio Valley --

A. Valley Physicians. I think they just re-branded.

Q. Huntington Behavioral Health, a Methadone clinic, MAT provided via individual doctors and Valley Health, which is a hospital, correct?

A. They're a federally qualified healthcare center. They are not a hospital.

Q. And as to those five we've just listed out, none of those are run by Cabell County or the City of Huntington, correct?

A. They are healthcare services.

Q. And none of them are funded by Cabell County or the City of Huntington, correct?

A. These are healthcare services.

Q. And these are healthcare services that would be able to seek reimbursement for their services from Medicaid and private insurance, correct?

A. Correct.

Q. Dr. O'Connell, we've been discussing a number of these treatment programs, of course, and talking about the different forms of treatment, outpatient treatment, residential treatment, medicated assisted treatment and so forth. Do you agree that the level of treatment that an individual needs for OUD depends on the severity of their OUD?

A. Yes.

Q. And the treatment should be individualized based on what the individual circumstances are for that person?

A. All treatment should be patient centered.

Q. And not everyone who has OUD needs every kind of

treatment, correct?

A. Correct.

Q. And not everyone who has OUD needs the same length of treatment, correct?

A. Treatment should be evidence based. So, treatment criteria should be for residential efficacy -- national research indicates no efficacy in less than 90 days for outpatient non-medication based treatment or residential treatment specifically and medication assisted treatment shows efficacy starting at one year.

Q. But not everyone is going to need that same length of treatment, correct?

A. That standard is based on efficacy, which is effectiveness of a program. So, it is saying that, with less than that, you are not likely to receive evidence based care. It would be the same as if your provider says you should receive eight weeks of chemotherapy and you receive six.

Q. And that might be a judgment made by individual providers, right?

A. Not the efficacy standard, no. That's from national data.

Q. If someone starts at a more intensive level of treatment, they don't always go to the lesser forms of treatment, do they?

A. We believe they should, that it should be a gradual stepdown and not just a clear-cut. We, in fact, often base that on the idea that -- we worked with a woman who had started her path of opioid misuse and dependency through a breast cancer diagnosis and she said the follow-up she received monthly, weekly and annually for many years after being in remission from cancer embarrassed her follow-up for substance use care and that it was deemed she graduated and there was not follow up. And so, our goal is these long-term engagements in the same way we do with other diseases.

Q. And is it a uniform path for everyone, though, through those steps or do they vary by individual?

A. We will always intervene with the individual's focus in mind. So, if an individual leaves Project Hope and graduates they, to do so, had to have started at a 3.5 and dropped to a 3.1. Once they're below a 3.1, we are not providing that care, but if -- we know that to maintain long-term success they need to be plugged into other levels that often wouldn't be intensive outpatient because they'd never be able to have the child care necessary to go to that many hours of outpatient treatment.

Q. So, they might not going to intensive? They might just go right to outpatient care?

A. So, we would try and find something that was going to

be effective for them that may include just outpatient services or in conjunction with other supports.

Q. So, your point is that people who start in inpatient might not necessarily progress to intensive outpatient but might just go to some other form of outpatient?

A. Because of the barriers around child care and workforce.

Q. You've discussed that some of the programs you work with have received grants from SAMHSA; is that right?

A. Correct.

Q. And SAMHSA, we've discussed, I think, but let's just be clear on this. It's the United States Substance Abuse and Mental Health Services Administration?

A. Correct.

Q. And SAMHSA provides grants to programs like the ones you've discussed that address substance use -- or substance abuse issues, correct?

A. Correct.

Q. It also does research on substance abuse and treatment?

A. Correct.

Q. And publishes data, correct?

A. Yes.

Q. And do you have an understanding that SAMHSA's data provides useful insights and inputs on substance abuse treatment programs?

A. Yes.

Q. Let me --

MR. HESTER: May I approach, Your Honor?

THE COURT: Yes.

THE WITNESS: Thank you.

THE COURT: Mr. Hester, this might be a good place to stop. I've got another matter.

MR. HESTER: All right, Your Honor. I'm sorry this is taking awhile, but --

THE COURT: Yeah. Your hour and a half has gone on a little bit longer.

MR. HESTER: I know. It's a little bit longer than I thought. Sorry, Your Honor.

MS. QUEZON: For the record, he promised he'd be done with this witness by lunch. He's not going to forgive me for this, Your Honor. I think I've used up all of my brownie points.

THE COURT: Well, as I said before, I've learned not to rely too much on lawyers' predictions.

MR. HESTER: Sorry, Your Honor. I'm getting close to the end. I will give you that much.

THE COURT: All right. Well, we'll come back at 2:00, Doctor.

THE WITNESS: I'll be here.

THE COURT: All right.

(Recess taken)

MR. SCHMIDT: Your Honor, may I say something briefly?

THE COURT: Yes.

MR. SCHMIDT: I just wanted to alert the Court that parties have started a discussion about whether there should be extra time in the plaintiffs' case and we're waiting to hear further specificity on that point from the plaintiffs and we'll certainly confer with them.

I did just want to say for the record that we have tried to be very disciplined in our case in terms of foregoing crosses on several witnesses, being shorter on a lot of witnesses. As a result, just time on the record, we're about 11 hours less than the plaintiffs, close to 50 minutes for the plaintiffs, 5-0, and 38, 12 for the defense. When we add in deposition designations, it gets even more divergent. 13 hours so far, 13 and a half hours so far from the plaintiffs, with the intention of calling more.

And I just want to put that on the record because that informs that discipline we've had and that caution we've had about using our time and the fact that we've come in much under time informs the position that we take, but we will confer with the plaintiffs.

THE COURT: Well, do we need to have an argument

about this now, Mr. Majestro?

MR. MAJESTRO: Yes, Your Honor. What I explained to defense counsel, we -- tonight at 7:00, we'll disclose our witnesses for next week and we're taking a close look at who we think we need to put on. We'll come back to the Court tomorrow with a specific ask and, prior to that, we will consult with defendants to see if we can reach an agreement.

We don't think we need to have an argument now. We'd like to get Dr. O'Connell off the stand. I'm sure she would like to, too.

MR. SCHMIDT: We don't have anything to ask beyond, Your Honor. We're prepared to move on with Dr. O'Connell. I simply wanted to note that for the record as we started discussing this.

THE COURT: Okay. Well, we'll fight this out as necessary.

MR. SCHMIDT: But I'm alerted to the fact there's an issue and I'm not the least bit surprised by that.

MR. HESTER: Good afternoon, Doctor.

THE COURT: Go ahead when you're ready, Mr. Hester.

MR. HESTER: Thank you, Your Honor.

BY MR. HESTER:

Q. Good afternoon, Dr. O'Connell.

A. Good afternoon.

Q. Just one housekeeping matter before we move on to just a few final questions. My colleagues told me they weren't sure that I had gotten a complete answer on one piece of this board and I just wanted to make sure that we had this.

So, we put up on the board when I asked you were there other treatment programs that you were aware of in Cabell-Huntington and you listed out five, OVP, the Huntington --

A. Behavioral Health.

Q. Behavioral Health, Methadone clinics, MAT available via doctors, and Valley Health. And I just wanted to confirm as to all of those five that you have added to this list we have worked on, those are not run by the City of Huntington or by Cabell County, right?

A. They are not.

Q. And those are not paid for or funded by the City of Huntington or Cabell County, correct?

A. They are not.

Q. And, in fact, the services, the treatment services that those five entities provide, are all paid for by or subject to reimbursement by insurance; is that right?

A. They would be able to submit for reimbursement.

Q. Thank you.

MR. HESTER: Your Honor, we would -- we would like

to mark this as Defendants' Demonstrative Exhibit 5 just so we don't lose track of it.

THE COURT: All right. It may be done.

BY MR. HESTER:

Q. Right before the lunch break, Dr. O'Connell, I had handed you a document marked as MC-WV-2126 [sic]. And on the first page, it bears the title "Treatment Episode Data Set 2018". Do you have that with you Dr. O'Connell?

A. I do.

Q. And this dataset, this TEDS dataset, is something that's published by SAMHSA; is that right?

A. It appears so.

Q. And you're familiar with this database, the TEDS database?

A. Yes.

Q. Let me ask you to look at Page 43, again, working off of the small numbers at the bottom, and it states under the introduction, this report presents national and state level data from the treatment episode dataset for admissions and discharges occurring in 2018 and trend data from 2008 to 2018. Do you see that?

A. I do.

Q. And then it goes on to say it summarizes demographic information and the characteristics and outcomes of treatment for alcohol and/or drug use. Do you see that?

A. I do.

Q. And is that consistent with your understanding of what the TEDS database does?

A. Honestly, we don't use the TEDS database for much, so i have no reason to doubt SAMHSA's writing in their own report.

Q. And SAMHSA, again, as we discussed, is a federal agency that oversees drug abuse issues at the federal level?

A. Substance abuse and mental health.

Q. Let me ask you to look at Page 79 of this document, please, again, using the small numbers at the bottom of the page. And so, this -- I wanted to ask you about figure 15 and the last bullet on the page there. And it refers to the median length of -- median LOS and "LOS" means length of stay, correct?

A. Correct.

Q. And it says the median length of stay among discharges that completed treatment was 143 days for outpatient medicated assisted -- medicated [sic] assisted opioid therapy. Do you see that?

A. I do.

Q. And is that consistent with your understanding that the median length of stay for people with OUD that completed treatment was 143 days for outpatient medicated assisted opioid therapy?

A. I would only have the information that's presented in that chart.

Q. Do you have any reason to doubt this information?

A. I -- if it's calling into question the idea of the reporting on 90 days of efficacy and over a hundred -- or a hundred for treatment, I would just acknowledge that treatment centers and treatment services that are provided are often based and limited by reimbursement.

For example, there's no actual research behind 28-day treatment, which became a name and then a length of stay due to that was the only amount of treatment that insurance would initially reimburse for. And so, it became a length of stay limited by the funding structure available.

Q. Well, but I wanted to ask you just about the data that's stated here and my question is do you have any reason to doubt the data stating that the median length of stay for outpatient medication assisted opioid therapy was 143 days? Do you have any reason to doubt that data?

A. No. I imagine they should update to the fact that length of stay for outpatient residential -- or outpatient medication assisted treatment wouldn't be actual stay.

Q. Well, it's a duration of treatment, correct?

A. Yeah. According to this, yes.

Q. So, if we understand that to be stating a median length of duration, 143 days for outpatient medication assisted

opioid therapy, you don't have any reason to doubt that that's correct?

A. That they are reporting that the median length of stay, the average, is -- just shy of 150 days.

Q. Well, it's 143.

A. 143 days.

Q. Correct?

A. Correct.

Q. And then -- and then it states the median length of stay for intensive outpatient treatment among people who completed treatment was 82 days. Do you see that?

A. Yes.

Q. And do you have any reason to doubt that data?

A. I'm not going to doubt SAMSHA's charting, no.

Q. And it states next, the median length of stay for people who completed treatment was 75 days for long-term residential treatment. Do you see that?

A. Yes.

Q. Do you have any reason to doubt that data?

A. That that is an average length of stay nationally, no.

Q. And then it states the median length of stay for people who completed treatment was 71 days for outpatient treatment. Do you have any reason to doubt that data?

A. No.

Q. And then it states the median length of stay for people

who completed treatment was 25 days for short-term residential treatment. Do you see that?

A. Yes.

Q. Do you have any reason to doubt that data?

A. No. And that would be conducive to the idea that most people leave treatment early if they're going to leave.

Q. Well, this is stating people who've completed treatment, correct?

A. Right, but if it's an average, that means that there's individuals surpassing that, but short-term treatment is capped at 28 days. So, to put it to 25 means the average was higher.

Q. Let me ask you to look back at a document you had discussed in your testimony before our break. It's -- no. Actually, I'm sorry. I'm going to ask you about another document first.

Do you recall discussing before the break, before -- before our week break from trial, you've discussed a Resiliency Plan that you and others had worked on. Do you recall that?

A. Yes.

Q. And I want to show you a document relating to that Resiliency Plan.

MR. HESTER: May I approach, Your Honor?

THE WITNESS: Thank you.

BY MR. HESTER:

Q. Dr. O'Connell, we've handed you a document, this one page e-mail marked as DEF-WV Exhibit 185. It appears to be an e-mail from Stephen Petrany dated April 19, 2019. Do you see that?

A. I do.

Q. And you received this e-mail, correct?

A. Yes.

Q. And this is discussing the Resiliency Plan that you and others worked on, correct?

A. Correct.

Q. And if you look -- if you look at the e-mail, the text of the e-mail -- and, again, Dr. Petrany was your -- is your boss, correct?

A. Correct.

Q. And he -- he states in the second sentence, attached, you will find a listing of active programs in our community addressing some aspect of Substance Use Disorder. Do you see that?

A. I do.

Q. And do you recall that there was this development of an initial list of programs that were engaged in treating Substance Use Disorder?

A. Vaguely. I recall that -- yes.

Q. And then, it goes on to say in the second paragraph,

our next survey asks you to consider ideas for building upon what we're already doing in our community. Do you see that?

A. Yes.

Q. So, here, the idea was build upon what is already being done in terms of treatment programs, correct?

A. Not necessarily.

Q. It states building upon what we're already doing in our community. Did you understand that to mean building upon what was already being done with treatment programs?

A. You're specifying treatment programs and that's not accurate.

Q. Okay. So, it's broader? Building upon everything that was being done in the community?

A. When we look at the City of Solutions, we are outlining a strong foundation that our community has. The Resiliency Plan is our goal of building a structure upon that strong foundation.

Q. So, starting with the foundation and then expanding it further, correct?

A. Correct.

Q. And that would include starting with the foundation of treatment programs that were already in place and expanding those further, correct?

A. Our treatment programs are one component of the current foundation in Huntington.

Q. And that was one piece of what you were looking at expanding upon, correct?

A. Correct.

Q. And then, Dr. Petrany says in the next sentence, if given unlimited resources, what ideas do you have for addressing the problem today and for the future. Do you see that?

A. I do.

Q. And did you understand that was the objective of this Resiliency Plan project, was to consider what you would be looking for if there were unlimited resources?

A. As I stated on the first day -- was that 2019? No, last -- two weeks ago, that our goal and what we had said with our focus groups was that we had asked folks to identify where we currently were, what short-term goals they had, and what long-term goals they had, and that the struggle there was that we are often limited in our thoughts based on our current process which, like I mentioned, is federal funding and grant opportunities. So, working beyond that scope was a challenge, but it was a goal.

Q. So, the goal was not to assume a budget? You weren't assuming some maximum budget? You were thinking of what you would do if you had unlimited resources, correct?

A. In each individual focus group, the -- it was stated what do you need in regards to this patient population or

area of issue or concern. So, in working with individuals who are unstably housed or not able to obtain safe and supportive housing, we started to think broadly about all of the areas that those individuals and those people working with those individuals knew to build upon.

Q. And without assuming any limit on the resources that you could -- could add to that?

A. We weren't tied to money. We were tied to the discussion about what the community needed to become healthy.

Q. And so, that's what Dr. Petrany meant to your understanding when he said unlimited resources, correct?

A. He was asking people to extrapolate and build.

Q. All right. Then I'd like to go back and just look quickly at the Resiliency Plan again.

MR. HESTER: May I approach, Your Honor?

THE WITNESS: Thank you.

MR. HESTER: Yes.

BY MR. HESTER:

Q. And, Dr. O'Connell, we've handed you what's been marked as Defendant's Exhibit 1447. This is the September 3, 2019 draft of the Resiliency Plan that you discussed in your prior testimony, correct?

A. Correct.

MR. HESTER: And I believe this is already in

evidence, Your Honor.

BY MR. HESTER:

Q. And I wanted to ask you to look at Page 32 again, using the small numbers at the bottom, please, and I wanted to ask you about the entry for outpatient and inpatient/residential services. Do you see that?

A. I do.

Q. And to the right-hand side, it provides examples of the expenditures that were in that category; is that correct?

A. In this current version of the draft, yes.

Q. So, one piece was, for instance, an expansion of MAT providers and services offered. That was one idea for expanding the services, correct?

A. Correct.

Q. And another was to expand the hospital inpatient unit for treatment drug hospitalization, correct?

A. Correct.

Q. And another idea was to increase capacity for addressing the effects of SUD over someone's lifespan, correct?

A. Yes. These are some examples.

Q. And am I correct that all of the treatment issues, all the treatment categories for OUD and NAS, were included within this category? This was the category where the expanded treatment was covered?

A. I believe so.

Q. And that would include treatment for NAS babies as an example?

A. Treatment for infants who were neonatally exposed would fall in part under that, but also understanding child -- the challenges with understanding the lifespan development of a child who is born neonatally exposed is not clearly understood as of right now. And so, that falls also under safe and supportive child care that's growing and advocating with that child and data and research so that we are doing longitudinal work to explore the needs of those children and families.

Q. The treatment of the -- of an NAS baby during the time that it has NAS would be included within the outpatient and inpatient residential services, correct?

A. Natal Abstinence Syndrome is only at birth, so the long-term diagnostic criteria for that child is unknown how long that -- what types of treatment and interventions are going to be necessary for the long-term.

Q. We just don't know, correct?

A. That's not my area of expertise as to current research and data on that.

Q. Would the treatment programs related with people with HIV or hepatitis arising out of intravenous drug use, that would be included within the outpatient and inpatient

residential services category, correct?

A. As the document states, there's multiple subsections and headings under each of the short-term and long-term outcomes.

Q. But I'm trying to understand if we're looking at any expansion for, for instance, hepatitis or HIV treatment, that would be an outpatient and inpatient/residential services, correct?

A. It could fall under some of the other categories.

Q. Which other category?

A. Community health, social support, early intervention, as well.

Q. The -- in terms of the expansion of services to treat people with OUD, that would be within the inpatient and outpatient and residential services category that we're looking at, correct?

A. Correct.

MR. HESTER: Those are all the questions I have, Dr. O'Connell. Thank you very much.

THE COURT: Is there any redirect?

MS. QUEZON: Yes, Your Honor. And I'm going to try to be brief and restore your confidence in the veracity of law, Your Honor.

THE COURT: Okay.

MS. QUEZON: Hope I'm successful.

THE COURT: I have plenty of confidence.

REDIRECT EXAMINATION

BY MS. QUEZON:

Q. Dr. O'Connell, I'm going to start where Mr. Hester just left off with that Resiliency Plan and, as we could see in that particular Resiliency Plan, there were still numbers included; is that right?

A. That is correct.

Q. Can you remind the judge whether in the final version there were any costs, money, associated with the needs of the community?

A. There were not. When we -- as all of the many drafts that we saw in court were labeled drafts and watermarked to that effect, it was our work while we were working through it to build off the research and the focus groups that we had and -- and ensure that our expertise in those areas was highlighted in that plan and the money and calculations were not deemed accurate or representative of our community and, therefore, were removed from our final and publicized document.

Q. And, Dr. O'Connell, Mr. Ruby spent a great amount of time going through those drafts and listing out the contributing individuals and contributing organizations. Do you remember that line of cross examination?

A. I do.

Q. And during -- and not taking away from any of their expertise in their own areas, but during the time that you and others were working on this Resiliency Plan, did you have a healthcare economist, a public health economist, working with you?

A. We did not.

Q. You were asked a number of questions by Mr. Ruby, I believe it was, regarding meetings with Mr. Farrell, myself, Ms. Kearse. Do you remember that line of cross examination?

A. I do.

Q. And in one of those meetings, do you recall whether or not there were any experts that had been retained by both the County and City present?

A. I believe in what I've referenced as the fourth meeting there were experts in attendance.

Q. And were -- did -- were other communities leaders present?

A. Yes.

Q. Did community leaders speak and give -- well, tell the judge. What did the community leaders do at these -- at this meeting?

A. The fourth meeting was the last one that I was in attendance and that was at Campbell Woods and, at that meeting, many community leaders addressed sort of where we were, what work had been done. We took the opportunity to

sort of reflect on, you know, another positive -- positive movements in the community and I believe both -- and predominantly shared some updates involving the future of litigation for the County and the community and some experts were introduced at that time.

Q. Now, I want to talk to you -- I think this was Mr. Mahady. And forgive me. It's been a week since we were here, but I think it was Mr. Mahady that talked to you about the grant application for the Great Rivers Region. Do you recall that?

A. I do.

Q. And I believe that was entered into evidence. And if we can pull that up. Yes, here we go. Now, did you write this grant?

A. I did not.

Q. Are you familiar with this grant?

A. I am.

Q. And do you know what the available monies were for the grant?

A. I believe, as I've indicated before, that -- and it was money that I had used the $2 million example before in saying we always left some money on the table. I believe that the opportunity was there for approximately $2 million to request.

Q. And so, from that, what was requested in this grant

application?

A. Was $1,999,206.00.

Q. Had the grant been for $1.4 billion, what would you have requested?

A. $100 billion, 999 thousand, 995, and maybe left some change on the table.

Q. All right. Now, and I do recall that Mr. Hester talked to you about the strategic plan earlier today; is that right?

A. That is correct.

Q. And if you can, explain to the Court what is this and what significance, if any, does it have?

A. As part of the Great Rivers Regional System for addiction care, the MERCK Foundation is really interested in seeing if what we've done is able to be replicated. So, they want in-depth dives into some of our programs like PROACT. They really like PROACT.

They're interested in the use of the Quick Response Teams in the use of harm reduction to address infectious disease and Substance Use Disorders. So, as part of that, because that grant is not treatment focused, it is purely a -- a coordination grant. The goal is to bring people together who are working on things and have them share resources and ideas. And resources in that case often being expertise or grant draft examples to share so that people

don't have to rewrite things.

So, as part of that, we were required to develop a strategic plan that sort of highlighted some disparities. The problem was the two evidence based tools that were used, the partner and the CAST, were incredibly burdensome and it actually also coincided with us removing an external evaluator from the grant who was not meeting their objectives. And so, we removed them and replaced them with a new evaluator.

So, but as part of that, we'd identified that the partner and the CAST and the evaluation tools that went into the strategic plan were not meeting our standards for responsiveness.

So, if I sent out a survey to find out about, you know, childhood mental health, you have to have so many people respond who can speak to that subject to say that it's accurate. And so, that is one limitation that I noted we've written into that strategic plan. Overall, its goal was to show multiple programs and different areas for need as we moved forward.

Q. Now, if we could bring up Defendant -- I think it's 2653, City of Solutions, and I know Mr. Hester spent some time on this particular document. And I want to talk to you a little bit about it. And if we can go to Page 6, under conceptualization, and before we go into detail on this

particular page, can you basically explain to the Court who all was involved in coming together and not -- you don't have to say specific names, but generally, who all was involved in coming together in order to put this document of what the community was doing together?

A. We tried to engage everyone who was doing things for the most part. We reached out to the executive of any of the major organizations and they either delegated someone who was on the ground doing the work or had multiple different individuals meet with us to go over the information.

And those were done through one-on-one interviews, information off websites, or just our knowledge of working side by side with these programs, which is why I was able to address programs that don't fall under the Marshall Health guidelines. We work very closely together in collaborative fashion.

Q. Dr. O'Connell, it lists some here with these initial stakeholders and it's got the City of Huntington and Marshall Health, Marshall University, the hospitals, the Cabell-Huntington Health Department and the Office of Drug Control Policy. Who is the Office of Drug Control Policy? Where does that come from?

A. The -- so, we are intimately connected with the state, the West Virginia ODCP, Office of Drug Control Policy, as

Bob Hansen had previously sat in my position -- or as director of the division and moved to become the Director of the Office Drug Control Policy.

And, as part of that, Marshall Health maintains a relationship. So, when Bob Hansen stepped down from the ODCP position, Dr. Matt Christiansen is now the newest Director of ODCP and he is a family medicine physician who sits in family and community health.

Q. Is it fair to say that the City and the County were involved in the creation of and coming to the table as key leaders of the City of Solutions?

A. It is. The tag line City of Solutions does come from the mayor's re-branding of the City of Huntington from the epicenter of the epidemic and as our -- our mayor, we started incorporating that new language and that is what got us both statewide and national recognition for these efforts.

MS. QUEZON: Now, if we could, can we bring up the -- and I don't know how to do it, Defendant's demonstrative 5 so I can see the list? I'm not going to write on it.

MR. HESTER: I think it's still there. I hope it is.

MS. QUEZON: Okay, I'll try. Oh, you got it? Oh, there we go. Okay.

BY MS. QUEZON:

Q. So, Dr. O'Connell, Mr. Hester went through treatment programs. They are listed on the left. And I think that all except perhaps Recovery Point, and that might be a little bit of a separate one, but in general, all of the treatment programs, are those healthcare programs?

A. MARC and MOMS both sit in the hospital system. Lily's Place is a separate but hospital medical based system. And Project Engage sits within the hospital system. PROACT being an -- external to the hospital, but run by the hospital system treatment center. And Project Hope also being an external from the hospital but medical based treatment center.

Q. And are there healthcare providers and, as you said, medical providers engaged in each of these treatment programs?

A. Recovery Point has a primary care team, but they do not -- you cannot be on medication assisted treatment and residing at Recovery Point.

Q. Okay. And you mentioned that one of the goals if you are running a healthcare program or a treatment program is to become fully reimbursable. Why is that so important?

A. Well, with any program that we set up, our goal is never to open and then shut the doors on people. That would be bad for treatment and the community. You don't want to provide hope and then take it away.

So, when we're working on anything, it's also a fact that as a part of any grant, you have to report a sustainability plan and, oftentimes, we report that as working towards billable services because that is one of the only current configurations for long-term sustainability in our community. There is no other set or structure.

So, we often then advocate to the State for changes in what they call like substance use waivers. And so, that may allow different treatment to be covered by a waiver that wasn't previously.

For example, certified peer recovery coaches can now be billed for under very strict guidelines and only under an LBHC, a licensed behavioral healthcare center, only in 15-minute increments, only after two years of recovery, and completion of certification.

Q. And so, as part of the goal in -- in having reimbursed programs so that there is reliable sustainable funding?

A. Yes.

Q. Now, Mr. Hester focused on treatment programs, but you and I talked a lot about some other programs that were part of the County. And I think the point here is are these run by the City or County and I want to talk a little bit about those and whether they can be reimbursed.

So, let's start if we can, and if you want to bring her slides back up, that might be the easiest way to do it. One

of the -- one of the programs you mentioned was the prevention empowerment program, PEP?

A. PEP.

Q. And let me just ask you, is that -- does Medicaid reimburse that? Is that reimbursable by any insurance?

A. No.

Q. How is that funded?

A. Exclusively grant funding and support originally from United Way of the River Cities.

Q. And we can go to Compass, which is I think about maybe seven slides in. Yes, there we go. Is this reimbursable by Medicaid or by any insurance program?

A. No. This is the program to address the helpers who need help, which is our Huntington Police and Fire Departments. There is no structure currently for any of those services to become reimbursable.

They are -- they started and are currently under the Bloomberg Philanthropy Grant and the City of Huntington has stepped in for the future of that for some of the staffing.

Q. Now, the -- I think the next maybe two slides over, there we go, the Cabell-Huntington Health Department and the Harm Reduction Services, and I -- and I don't know the answer to this. Are some of those reimbursable?

A. The reason that we integrated the peer recovery coach services there was to try and initiate services. However,

those cannot be employed by the Health Department because they're not a licensed behavioral healthcare center. So, they couldn't bill for that. So, Marshall Health can employ peers that we then establish at the Health Department.

And just briefly, if we take peers, for example, on reimbursement, peers can be reimbursed for up -- for approximately 15-minute increments. Well, a lot of peer engagement is informal. That's the goal, is to come alongside someone and say I can help you. I was also in your shoes. I can take you to that meeting.

Now, that meeting wouldn't be covered or reimbursable. The trip, the car ride there, may now be reimbursable, but then, for example, the supervision of our peers where we make sure that we're covering their recovery, we don't want to just let people out and then not provide them support and care because they're individuals in recovery who need their own support when they're engaging regularly with their old negative people, places and things, which are the things we tell them to change. So, we have to provide a lot of supervision services. None of those would be covered.

Q. Now, how about the Quick Response Team? And that is -- and I know kind of already testified before the Court, so we won't go into great detail, but this is started by the Cabell County EMS, correct?

A. Correct.

Q. And are any of these reimbursable through either Medicaid or insurance?

A. Not currently. Again, the only way that we're trying to set this up moving forward would be to support the peer through a -- another licensed center. So, Prestera Center, for example, has their peer on loan to the Quick Response Team so that they can reimburse or often eat that cost and wrap it under the larger structure and hope that there's reimbursement somewhere else that covers these other supportive services that we know we need.

So, we have to do that a lot. If there's -- we know we can be reimbursed for A, but to keep that person in recovery, meaning B and C, we'll cover those through the in-house.

Q. And then, finally, let's just talk about CORE, the Creating Opportunities for Recovery Employment. Again, same question. Are any of those services reimbursed by Medicaid or by private insurance?

A. They are not. And this would be the example specifically if we can have someone in long-term recovery but they can't get a job, why are they going to stay in long-term recovery? We have to be providing all of these auxiliary supports that aren't really auxiliary. They're key to that person's long-term success.

And so, for CORE, we build it under PROACT in hopes

that when PROACT eventually breaks even that CORE would continue to be supported and invested in because, without it, sometimes we're wasting money, right, or we're never wasting money on an individual. A single day in recovery is worth spending money on, but if we're not providing the consistent wrap-around support services, then that person ends up back in substance use when we know we could have intervened with something that we should be intervening with that other thing.

Q. And then, finally, Dr. O'Connell, if we could bring up Defendant's Demonstrative 5 again. Now, I know Prestera started back in the 60s, late 60s or something like that?

A. I was surprised even how old they were according to their website.

Q. Wait a second. '67, which is my birth year, so let's not go crazy here. All right. Now, but let's look at the others, if we can here. PROACT, do you know when that began?

A. 2017, 2018.

Q. And why is it necessary in the community? Why did it have to start in the first place?

A. We -- we still do, but at that time, if you wanted treatment there was nowhere you could walk in the door and say I have a problem. I need help. You would be told there was a 60, 90, forever long wait list and no Emergency

Department or even treatment center allowed you really just to walk into the lobby and say you needed help. PROACT exclusively does that.

Q. And was it necessary for the community?

A. It's paramount to the success of our community.

Q. All right. Let's talk about MARC. When was that created? And that's the Maternal --

A. Addiction Recovery Center.

Q. Would the Road to Recovery have the --

A. It would have the dates on it.

Q. Is that the easiest way?

A. I know it's in one of these.

Q. Can you pull up the recovery?

A. Dates are not my forte'.

Q. Might be like the third page of the slides, the Road to Recovery.

A. Oh, yeah.

Q. Looking at the Road to Recovery -- oh, there we go. All right.

A. The MARC Program, so MOMS started in 2018. The MARC Program did exist before then.

Q. Yeah. It is --

A. Yeah. Okay, yeah. The MARC Program started in 2012 and that, I believe, was when they saw a significant -- the NICU, the Neonatal Intensive Care Unit, was being

overwhelmed by infants with exposure.

Q. And was that necessary for the community?

A. That dramatically changed the treatment of infants with exposure.

Q. All right. Let's go on to MOMS. I think that's the next one that was on Mr. Hester's list.

A. It is 2018 down at the bottom there.

Q. And why did that have to be created?

A. Again, that idea that we would identify -- we would identify something, develop a program, and then it would illuminate three other needs or ten other needs.

So, we had the MARC Program and we're saying great. We have women who are pregnant able to receive treatment and care while they're pregnant. Well, then they would deliver the baby and the baby would receive treatment in the NTU, but Mom wasn't and she was being held responsible for not being there for visitation for the NTU because she would maybe be off somewhere getting help. So, the MOMS Program then picked up on that need.

Q. And was it necessary for the community at the time?

A. I believe so.

Q. What about Lily's Place?

A. Lily's Place recognized the need after the NTU and the MARC Program that there was an even greater need than just the hospital based care and that the hospital setting

continues to be a struggle for infants who are exposed because of the stimulus and Mom's inability to visit all the time. And so, Lily's Place provided a much needed community-based setting for that to occur.

Q. And if we go back to demonstrative 5 -- so, Dr. O'Connell, not to belabor the point, but were each of these created other than, again, Prestera, which was an older program, were each of these created because of the need in the community?

A. Absolutely. They met a specific need and a population that was not being served.

MS. QUEZON: May I have a moment, Your Honor?

THE COURT: Yes.

(Pause)

MS. QUEZON: No further questions, Your Honor.

THE COURT: All right. Is there any re-cross?

MR. HESTER: Yes, Your Honor, just a little bit.

THE COURT: An hour and a half, Mr. Hester?

MR. HESTER: I promise you I'll be better than that, Your Honor.

RE-CROSS EXAMINATION

BY MR. HESTER:

Q. Dr. O'Connell, just a few questions and then we'll let you go. Let me ask you if we could pull up the plaintiffs' slide deck, Demo 224, Page 8, please.

Dr. O'Connell, you were asked about PEP. How much money does the community spend on PEP?

A. Not enough.

Q. There's no money spent on it, correct?

A. The community -- the money that we receive for PEP is run through the United Way of River Cities.

Q. So, the City of Huntington and Cabell County don't put money into PEP?

A. There is money from the Cabell County school system, so I do not know if that runs through the Cabell County budget.

Q. Most of the funding for PEP comes from United Way?

A. Through the CADCA grant, which stands for something. Stands for -- I do not actually recall what the CADCA grant stands for, but it's federal funding for prevention.

Q. And how much money is that, do you know?

A. In their first five years, I believe, annually they had SAPT funding, which is student-something prevention funds. And that was $70,000.00. And then the -- the DFC funding, that's what it is. It'S -- CADCA runs through the Department of Family and Children's and I believe they received maybe around $200,000.00 and those funds for both of those, SAPT funding has ended and DF -- DCF or DFC funding will end in October of this year.

Q. But the annual funding during the time that the funding was available, the annual funding was in the range of

$250,000.00?

A. Probably.

Q. Let me ask you about Compass, Page 11, please. This is another one you were asked about, correct?

A. Correct.

Q. And this is not providing treatment to people with OUD, correct? It's dealing with first responders?

A. This -- it works with the Huntington Police and Fire Department irregardless of their substance use experience.

Q. But when it says designed to provide first responders with tools to improve their ability to deal with high stress situations, that's not an OUD issue, is it?

A. In some cases, it is.

Q. So, this would be treating people who've had OUD?

A. We have had Huntington Police and Fire, unfortunately, experience Substance Use Disorder and Compass in part grew out of the need to not only address that, but overall health and wellness, including suicidality.

Q. So, it's health and wellness for the first responders community, correct?

A. And their families.

Q. And how much money goes into that? Is it correct to say it's about $350,000.00 annually?

A. I am not sure. That may be the -- well, it was funded by the Bloomberg grant initially, which was a million-dollar

award for -- there's three full-time staff on the project and the construction of some wellness resources and the three staff are now part of the City's budget.

Q. And so, it's roughly in the range of $350,000.00, or you don't know?

A. It was a million-dollar grant.

Q. Over multiple years?

A. Over -- well, we got $100,000.00 to pilot the grant initially. And then, I believe it was two years with the remaining funds.

Q. So, a million-dollar grant covering two years?

A. I believe so.

Q. And then --

A. Three. Probably three. They're normally three years.

Q. Covering three years, do you think it was?

A. I believe so.

Q. So, it was a million-dollar covering three years of the program?

A. I believe so.

Q. Let me ask you at Slide 13, please, you were asked about these Harm Reduction Services provided by Cabell Huntington Health Department, all that. Is it correct that all of those Harm Reduction Services are subject to reimbursement except for provision of needles?

A. Narcan training is not covered for reimbursement

status. Social work services are not necessarily covered by reimbursement status. I already explained the peer services. And then any -- any services providing syringes or other auxiliary, clean water, other tools, are not covered both by any reimbursement nor by grant funding.

Q. So, some pieces of the Harm Reduction Program are subject to reimbursement?

A. As I said, the majority of those listed are not.

Q. And the total budget for the Harm Reduction Services each year is in the range of $220,000.00, correct?

A. I have no idea what their current budget is.

Q. That would be shown on the City budget?

A. I don't know. I believe they operate -- I don't know.

Q. You were asked about the Quick Response Team. The annual spending for the Quick Response Team is about $225,000.00, right?

A. That is correct.

Q. And some of that's provided for by grant funding; is that correct?

A. All of that is currently -- the Quick Response Team is singularly supported by grant funding or matched because the -- one of the two grants, whether it was ECI or BJA, requires a match for funds. And so we use -- for example, the vehicle. Cabell County EMS provided the vehicle and then could be used as a match towards the grant funding.

Q. And the -- some of the funding is coming from the State of West Virginia, correct?

A. No.

Q. For the QRT?

A. Not for the Huntington Quick Response Team.

Q. You say the match funding. Where does that come from?

A. So, Cabell EMS would provide some. I work on the grant and my time is not reimbursed, so that's matched. They receive trainings from the domestic violence shelter. That would be considered matched in hours. The Narcan that they receive could be considered matched funding. So, it's -- time is often how we match. We don't have a lot of other money to throw at this in a financial way.

Q. And when you say matched, do you mean you're providing in kind services to support the QRT?

A. That is required by the grant, for the awarding of the grant.

MR. HESTER: Thank you, Dr. O'Connell. That's all I have.

Thank you, Your Honor.

THE COURT: Is there anything else of Dr. O'Connell?

MS. QUEZON: Mercifully not from the plaintiff.

MR. RUBY: Judge, I have one question. Just one.

THE COURT: Okay.

RE-CROSS EXAMINATION

BY MR. RUBY:

Q. And I promise, Doctor, this is the only one.

A. Multiple parts?

Q. Pardon me? Pardon me?

A. Multiple parts?

Q. No, just one.

There was never a version of the Resiliency Plan that included more than $50 million over 40 years for treatment, was there?

A. There is no final draft or final version of the Resiliency Plan with money tied to it.

Q. Was there ever a version that included more than $50 million over 40 years for treatment?

A. There are no drafts of the Resiliency Plan that change that financial amount and because we didn't believe that we knew what we were doing with the money accounting, there is no final draft with money tied to it.

Q. Okay. Well, I want to make sure we're communicating. I understand you're talking about the final draft. Was there ever any draft of the Resiliency Plan that included more than $50 million over 40 years for treatment?

A. I want to stand behind the final version of the document and not multiple iterations of it where there were changes made consistently to different sections.

Q. And I'm trying to stick to my one question. You are aware that there were multiple drafts of the document, correct?

A. There were countless drafts of the document.

Q. And some of those drafts included cost figures, correct?

A. There are draft versions that contained finances.

Q. And in any of the versions -- let's just focus on the versions that contained the finances. In any of the versions that contained cost figures or finances, were there any of those that included more than $50 million over 40 years for treatment?

A. I believe I recall last Friday going through multiple versions and having answered this and said no.

MR. RUBY: Thank you.

THE COURT: Anything else of the doctor, Mr. Mahady?

MR. MAHADY: I have no further questions. Thank you for your time.

THE COURT: Going once --

THE WITNESS: Sold. Sold. Done. Don't auction it off.

THE COURT: Thank you, Dr. O'Connell --

THE WITNESS: Thank you.

THE COURT: -- for your patience with us.

THE WITNESS: No problem. Thank you for having me.

THE COURT: And you're free to go. Thank you very much.

THE WITNESS: Thank you. Should I leave all of this somewhere?

THE COURT: You can just -- just leave it and somebody will get it.

THE WITNESS: Okay. The recycling bin, please tell me.

Thank you, Your Honor. Have a good day.

MS. SINGER: Good afternoon, Your Honor.

THE COURT: Good afternoon.

MS. SINGER: Linda Singer for the City of Huntington. I see all of these people rising.

COURT REPORTER: I'm sorry. What was your name again, ma'am?

MS. SINGER: Linda Singer. So, Your Honor, I think, as you're aware, the plaintiffs intend to call Joseph Rannazzisi to the stand and anticipate the defendants may have some issues I wanted to raise. I wanted to, very briefly, with the Court's permission, raise a few preliminary issues.

COURT REPORTER: Is your mic on?

MS. SINGER: Can you not hear me?

COURT REPORTER: Is it on?

MS. SINGER: It is.

COURT REPORTER: Okay.

MS. SINGER: And you would think I'd be close to it.

First, Your Honor, as you may be aware, Mr. Rannazzisi is appearing with authorization from the U. S. Department of Justice pursuant to a Touhy authorization. I am happy -- I will show it to the witness. I am happy to provide a copy to the Court, but I did want to make sure the Court is aware that his testimony will be constrained both by the terms of his Touhy authorization.

I understand, with the Court's permission and the consent of the parties, that there is a representative of the U. S. Attorney's Office here who will stand in for the Department of Justice to raise any objections. I don't know if that person wants to introduce themselves and enter an appearance, but I did want to create that space.

MR. WESTFALL: Your Honor, Fred Westfall for the U. S. Attorney's Office on behalf of the Department of Justice.

THE COURT: All right, Mr. Westfall.

MS. SINGER: And I'm ready to start if the defendants don't have any issues they want to raise.

MR. SCHMIDT: No. We -- we had raised our concern

with the plaintiffs when we got their exhibits that they were well outside of what the representation was made to the Court this was only a fact witness constrained by his MDL testimony.

We've been told -- haven't talked directly to Ms. Singer, but by her colleagues, that they'll stick within that. So, I'm hoping we won't need to object to many of the materials that they identified last night which would be objectionable, but we'll deal with that as it arises, Your Honor.

THE COURT: All right. I will deal with those as they come up and I have ruled that Mr. Rannazzisi is a fact witness, but not an expert, and we'll have to -- just want the facts, Ms. Singer.

MS. SINGER: That's my job, Your Honor, and I'm sure that's what Mr. Rannazzisi is prepared to do.

I will note that the other aspect of Your Honor's ruling is that on defendants' motion and with plaintiffs' agreement, we are not offering Mr. Rannazzisi for anything beyond the scope of his prior deposition in the MDL. To the extent that there are issues, I know that we will deal with them.

And I assure Your Honor that that was a two-day very vigorous and expansive deposition which covered many of the issues the Court has heard about over the last several

weeks, ARCOS, and suspicious orders, and DEA's guidance, and enforcement. So, I think there will still be plenty that Mr. Rannazzisi can cover as a fact witness within those bounds and, with the Court's permission, we'll go ahead and bring Mr. Rannazzisi into the courtroom.

THE COURT: All right.

MS. SINGER: Thank you.

THE COURT: You may proceed.

Mr. Rannazzisi, if you want to come up and take the oath.

COURTROOM DEPUTY CLERK: Would you please state your full name?

THE WITNESS: Joseph Rannazzisi.

COURTROOM DEPUTY CLERK: Thank you. Please raise your right hand.

JOSEPH RANNAZZISI, PLAINTIFF WITNESS, SWORN

COURTROOM DEPUTY CLERK: Thank you. Please take a seat.

THE WITNESS: Good afternoon, Judge.

THE COURT: Good afternoon, Mr. Rannazzisi.

MS. SINGER: I think I was taller when we got started with this trial, Your Honor, but I will try to make it over the podium.

DIRECT EXAMINATION

BY MS. SINGER:

Q. All right. Mr. Rannazzisi, can you introduce yourself to the Court, please?

A. My name is Joseph Rannazzisi. I'm a retired DEA special agent.

Q. And, Mr. Rannazzisi, are you aware that you are authorized to testify today pursuant to the terms of a Touhy authorization?

A. Yes, ma'am.

Q. And have you seen that Touhy authorization?

A. Yes, ma'am.

MS. SINGER: Your Honor, may I approach the witness?

THE COURT: Yes, you may.

BY MS. SINGER:

Q. And, Mr. Rannazzisi, do you recognize the document that we've just handed you?

A. Yes, ma'am.

Q. And what do you recognize it to be?

A. The Touhy letter that was sent to me outlining what I can and can't disclose in testimony.

Q. Okay. And you're aware that you're here as a fact witness, are you not?

A. Yes, ma'am.

Q. Have you prepared a report related to opioid distribution or diversion in Huntington or Cabell County?

A. No, ma'am.

Q. Are you offering any expert opinions?

A. No, ma'am.

Q. Are you -- are you receiving any compensation for being here today?

A. No, ma'am.

Q. Why did you agree to testify here?

A. I believe that the facts should be presented in this case, as well as the other opioid cases that are across the country, because the public needs to be aware of what went on and this is my opportunity to do that.

MS. SINGER: All right. Gina, can we bring up the demonstrative road map, please?

BY MS. SINGER:

Q. Well, hopefully, given where we are in the day, Mr. Rannazzisi, I don't think we have too long a journey. I did want to lay out just briefly an outline for what my hope is that you will cover over the course of this day.

We will go through your background, closed system, guidance that DEA provided to registrants, ARCOS data, suspicious orders, enforcement, the DEA's enforcement related to these defendants. What I've put here is endorsement, which is whether DEA approved any of these programs, prescribers, some of your prior testimony, quota, and then wrap up.

So, I just wanted to lay that out for the Court and for you. Hopefully, we can get through all of that efficiently. If it's too much, I think it's too late now.

MR. SCHMIDT: And just -- I would request a copy of the demonstratives. We got a demonstrative last night. It did not include this.

MS. SINGER: It's not a demonstrative, but you have all of the other slides.

MR. SCHMIDT: We don't have this one. If we could get a copy of any slides you plan to use.

BY MS. SINGER:

Q. So, Mr. Rannazzisi, how long did you work for the Drug Enforcement Administration?

THE COURT: Well, just a minute.

MR. SCHMIDT: Your Honor, may I get the -- we have a copy of that. No, the demonstrative that they just used. It would be helpful for us to have one.

THE COURT: Oh, the one she just put on the board?

MR. SCHMIDT: Yes, please.

THE COURT: Do you have a copy of that you can give him, Ms. Singer?

MS. SINGER: We will get one.

MR. SCHMIDT: I appreciate that.

BY MS. SINGER:

Q. Mr. Rannazzisi, let me ask you again, how long did you

work for the Drug Enforcement Administration?

A. Worked for the Drug Enforcement Administration from March of 1986 until October 31st, 2015.

Q. What position did you hold? I think you said you retired. What position did you hold at DEA when you retired?

A. It was a Deputy Assistant Administrator for the Office of Diversion Control.

Q. Now, prior to becoming Deputy Assistant Administrator, what other positions did you hold at the DEA?

A. I was a Deputy Chief of Enforcement Operations, the Deputy Director of the Office of Diversion Control for a brief period of time. I was an Assistant Special Agent in Charge in the Detroit Field Division. I was a Section Chief in the Dangerous Drugs and Chemicals Section in DEA headquarters. I was a Staff Coordinator in that same section.

I was also a Group Supervisor in the Detroit Red Room, Homicide Task Force. Prior to that, I was a special agent. And before that, I was a diversion investigator.

Q. All right. So how much of your career have you spent at the DEA?

A. I've been at the DEA --

Q. Yes. Meaning have you worked anyplace else? Has this been your entire career?

A. Prior -- prior to my entry employment with the Drug Enforcement Administration, I was a staff pharmacist at the Veterans Administration Hospital in Indianapolis, Indiana.

Q. So, would it be fair to say that you've had both field and headquarters positions at the DEA?

A. Oh, absolutely, yes.

Q. And let's turn back before your time at the DEA. What was your major in college?

A. I received a Bachelor of Science in Pharmacy from Butler University in Indianapolis.

Q. And why Pharmacy?

A. My career choices. I was going to move into law enforcement. I wanted to be in narcotics and law enforcement, I figured the pharmacy background would present a very good background to get into narcotics law enforcement.

Q. And did you work when you were in college?

A. Yes. I worked multiple jobs. I was a security guard at a children's museum. I was a library tech. I was also in the Fire Department. I was both a firefighter and EMT.

Q. And after college, Mr. Rannazzisi, did you have any additional education?

A. After college, after a few years, I went back and received a law degree from Detroit College of Law at Michigan State University.

Q. And you said that your major in college was in Pharmacy. Did you ever practice as a pharmacist?

A. Yes, ma'am. The -- I was both -- I interned at Hook's Drugstore, which was a retail pharmacy. And then, when I passed my pharmacy boards, I worked at the Veterans Administration, both inpatient and outpatient pharmacy.

Q. Why did you join the DEA?

A. I wanted to be in narcotics law enforcement. I grew up in the 70s. There were a lot of issues with drug abuse and drug addiction.

In the neighborhood that I grew up in, it was mostly firemen and police officers. In fact, my best friend's father, who I looked up to, was a police officer.

There was a former DEA -- a DEA agent that was killed during an undercover operation. And all of that just worked into my reasoning that, you know, this is something that will help the public and, because of that, I decided that was going to be my chosen profession.

Q. At some point, I think you mentioned in your career at DEA, did you move into drug diversion in particular?

A. Yes.

Q. And explain how that came about and when that was.

A. Well, again, in -- as a diversion investigator, when I start -- when I initially joined the Drug Enforcement Administration, when I initially applied to the Drug

Enforcement Administration, the special agent slots were extremely hard to get. You needed experience. And, while I was a pharmacist, I didn't have the law enforcement experience.

I became a diversion investigator because I obtained that experience and then moved into the special agent role. So, yes, I was a diversion investigator for two years and, at the back end of my career, I again oversaw diversion.

Q. And other than your work in diversion at the beginning and end of your career, did you do street level enforcement on non-diversion investigations?

A. Yes.

Q. And did your work in drug diversion connect with any of the non-diversion cases that you had been working on before? Was there any kind of common thread?

A. Well, DEA investigations, be it from illicit drugs or pharmaceuticals, are basically the same. You're going -- you're investigating people who are selling drugs that are harmful to the public. So, yeah, there was a lot of crossover.

I did undercover on -- on pill cases. I also did undercover on cocaine, and methamphetamine, heroin cases. But they really converge because pills, like the drugs, are harmful to the community if they're provided in a manner that's unsupervised and, you know, illicit.

Q. At some point during your career, did you observe an increase in the diversion of prescription opioids?

A. Yes, sir -- yes, ma'am.

Q. And can you explain when -- when that happened?

A. We -- we observed prescription opioids throughout the 80s and 90s. Before -- right before I was transferred into headquarters to become the Deputy Director of the Office of Diversion Control, I received a group of briefings before I got there, and then when I got there, and we were looking at pharmaceuticals, specifically pharmaceuticals that are being trafficked off the internet.

And so, yes, I noticed based on the numbers and based on other things that I was seeing from headquarters that this internet trafficking was taking over a lot of the pharmaceutical issues and diversion that was happening in the United States across the country.

Q. And then even before internet pharmacies, had you noticed, before you were in headquarters, any increase or change in prescription drug diversion?

A. Yes. The problem with prescription drug diversion, it was very localized in the 80s and throughout the mid-90s. We were -- you had bad doctors, a few bad pharmacies. The numbers weren't really -- they weren't huge numbers.

Towards the mid- to late-90s and into the early 2000s we started seeing increases in the amount of drugs both

coming out of the -- into the pharmacies and coming out of the pharmacies and they were oxycodone products, hydrocodone products secondly. And as we started seeing these drugs more and more, you know, we -- we understood that the problem was getting progressively worse.

Q. And was it a difference in scale, in number, or in type of diversion? How would you describe that?

A. Well, the normal diversion, when we -- when you say diversion in the sense of the 80s and 90s, we were seeing a lot of prescription fraud. We were seeing a lot of doctor shopping. We were seeing robberies, burglaries, things like that. Those are your normal diversion patterns. Bad doctors who were writing scripts.

As we got into the 2000s and to the early to mid-2000s, it wasn't anymore that a doctor or a pharmacy was dispensing a few thousand tablets. It was a pharmacy or -- was dispensing a few hundred thousand tablets. The volume increased dramatically and it switched to hydrocodone. We started seeing a huge quantity of hydrocodone coming out.

We saw Alprazolam, which is a Benzodiazepine. We saw Phentermine. So, the quantities were increasing dramatically. So, we went from a -- a locally based -- groups that were burglarizing, they were passing bad paper, -- passing bad prescriptions, doctor shopping, bad doctors. We were moving into this -- this nationwide problem where

the numbers were out of control.

Excuse me. I need some water, please.

THE COURT: Mr. Rannazzisi, will that help you?

THE WITNESS: Yes, sir. Thank you very much, sir.

MS. SINGER: That's throwing yourself on the mercy of the Court, I think.

THE WITNESS: Thank you, sir.

BY MS. SINGER:

Q. So, Mr. Rannazzisi, where in this cycle in the development of prescription drug diversion did you move into headquarters?

A. I was right at the -- I was probably a year into -- when I got there, we were a year into maybe -- a year to two years into the internet at that point in time. We started seeing -- by 2004, by mid to late 2004, we were seeing large volumes of hydrocodone and Alprazolam coming out of the internet and, yeah, when I got to headquarters, that's what we were looking at.

Q. All right. And what year did you become Deputy Assistant Administrator?

A. When I got into headquarters, I was Deputy Director, which was the number two position in the Office of Diversion Control. I didn't -- I left there towards the end of 2004 to become the Deputy Chief of Enforcement Operations and I returned basically in July of 2005 to take over the office

because the then Deputy Assistant Administrator was deployed in the military and they needed to keep that position open.

Q. And where does -- so, let's move to the time when you became Deputy Assistant Administrator in the Office of Diversion Control. Where does that sit within the DEA hierarchy?

A. The Office of Diversion Control Deputy Assistant Administrator doesn't really exist anymore. It's now an Assistant Administrator position. When I was there, I reported to the Chief of Operations, who was an Assistant Administrator, and I also had reporting authority to the Deputy Administrator and the Administrator, depending on what -- what I was doing at the time. So, I had overall control of all diversion operations.

I was also a Deputy Chief of Enforcement Operations under the Enforcement Chief and I also reported to the Deputy Administrator and, depending on what we were doing, the Administrator.

Q. And so, within that suite of responsibilities, what specifically were your duties as Deputy Assistant Administrator?

A. My duties, oversee all major investigations regarding pharmaceuticals and listed chemicals, clandestine lab operations, promulgating regulations. I was the liaison to law enforcement related to clandestine laboratories

pharmaceutical investigations. I was industry liaison.

I was pretty much anything that diversion touched. I was the competent authority for chemicals. Anything that diversion touched, I oversaw.

Q. And did you have any responsibility with respect to quota, or advocacy, or other law enforcement entities?

A. One of my duties was the -- overseeing the establishment of the aggregate production quota in the United States for Schedule II and Schedule II products, Schedule I products and Schedule III narcotics.

Q. And did you have any liaison responsibilities outside of the Federal Drug Enforcement Administration?

A. Again, I -- I was the liaison to law enforcement agencies. I was liaison to International Association of Chiefs of Police, all the regulatory agencies, and also industry.

Q. Have you received any recognitions during your career for your service?

A. In I believe it was 2008 I received the Presidential Meritorious Service Award from Attorney General Holder. I think it was submitted under Attorney General Gonzales. I was also given a Hosta [sic] Award from the National Association of Boards of Pharmacy for service, public service. The National Narcotics Office Association Award for services narcotics officer and Oklahoma Board of

Pharmacy gave me an honorary Doctor of Pharmacy award.

Q. All right. Let's turn and I won't pull the road map up, but let's turn from your background to the closed system was the next place on our journey. So, can we pull up demonstrative slide 2, please,

MS. SONGER: May I approach, Your Honor?

THE COURT: Yes.

BY MS. SONGER:

Q. Mr. Rannazzisi, have you heard the term closed system applied to the supply chain for distributing controlled substances?

A. Yes, ma'am.

Q. And take a look at the slide that's up on the screen, sir, that I just handed you. Do you recognize this graphic?

A. Yes, ma'am.

Q. And what do you recognize it to be?

A. This is a depiction of the Closed System of Distribution, how the Closed System of Distribution should work. And we use this slide pretty -- well, when I was with DEA, we used that slide pretty regularly.

Q. And what does Closed System mean with respect to pharmaceutical -- pharmaceutical controlled substances?

A. The Closed System Distribution is a system of security and accountability. Theoretically, we should be able to account for any amount of drug that starts at the

manufacturing import level and goes all the way down to the pharmacy and hospital level before it's dispensed to patients. That system of accountability is done on any number of things, but things like audits, inventories, security checks. We ensure that all the security is appropriately maintained, both electronic, physical, vaults, cages, things like that.

So, this Closed System of Distribution overall is just a system of accountability to ensure that nothing is leaving the system and going into the illicit marketplace, in a system where we could either retrospectively find out that it's been -- it left the system and investigated it or prevented from our system of -- from our inspections and audits. That's all the closed system is.

Q. And who are the participants in the closed system?

A. The DEA registrants throughout the supply chain, importers, exporters, manufacturers, distributors, doctors, pharmacists -- or pharmacies, hospitals, pretty much anybody that touches drugs except for pharmacies and -- pharmacists and nurses are -- are registrants and they all are involved in the closed system of distribution.

THE COURT: I'm sorry to interrupt you, but we need to take a short break here.

You can step down during the break, Mr. Rannazzisi.

THE WITNESS: Thank you very much.

THE COURT: We'll be in recess for -- try to keep it to ten minutes.

(Recess taken)

THE COURT: You may resume the stand, Mr. Rannazzisi.

THE COURT: Go ahead, Ms. Singer.

BY MS. SINGER:

Q. So, Mr. Rannazzisi, I don't know if you've ever been accused of being soft-spoken, but please make sure to keep your voice up. I know it's late in the day, but for the court reporter's benefit, please.

A. Yes, ma'am.

Q. Okay. I think you were at the participants in the closed system. So each of the arrows are different participants in the closed system; is that correct?

A. Yes, ma'am.

Q. And are each of those participants called registrants?

A. Yes, each one of those are registrants with the exception of the patient.

Q. And when you worked for the DEA, how many registrants were there?

A. Approximately one point -- I'll say 1.6 million.

Q. And how did that break down among the different categories?

A. The vast majority of the registrant population are

prescribers, either doctors or mid-level prescribers, physicians.

Q. And beyond doctors, what are the other major categories?

A. You have pharmacies, between 65- and 70,000 at that time; hospitals, I can't give you a quantity of hospitals. Then you had manufacturers, distributors, probably a little over a thousand of those total. So --

Q. Now, is the DEA a participant in the closed system?

A. The DEA oversees the closed system. The DEA provides oversight and -- regulatory oversight over the closed system of distribution.

Q. Okay. But it's not in the circle itself; correct?

A. No, ma'am.

Q. What is the reason for the closed system of distribution for pharmaceutical drugs?

A. We would like -- we need to know exactly what is in the system at the time from the manufacturing point all the way down to the retail hospital level. And we need to prevent those drugs from being diverted into the illicit market.

So the purpose of the closed system is to ensure that there is tools in place to ensure that the drugs aren't flowing to the illicit marketplace.

Q. And what happens if drugs escape from the closed system?

A. You get diversion.

Q. And what happens when drugs are diverted?

A. They're used illicitly. People become addicted, people overdose, and people die.

Q. What are the obligations of participants -- or registrants or participants in the closed system?

A. They all have their own specific set of obligations under the Controlled Substances Act. Manufacturers and distributors share certain aspects or obligations under the Controlled Substances Act. Practitioners and pharmacies also share some of the same provisions, but they also have different provisions within the Act as well.

But they all have an obligation to maintain effective controls against diversion. That's the one thing common among all of those registrants in the closed system of distribution. They must maintain effective controls against diversion.

Q. Can the DEA police all of the different participants in the closed system?

A. It's extremely difficult with the number of people that we have to look at, all the practitioners and all the retail pharmacies, and then concentrate on the manufacturers and the distributors as well. We don't have a huge amount of resources to do that.

Q. And is that a constraint that you disclosed to the

regulated entities or the registrants?

A. Oh, absolutely. That's the basis of the closed system of distribution and the basis of why Congress implemented certain provisions within the Act and regulations -- and in the regulations to ensure that there was assistance being provided and oversight being provided by the industry.

Q. Now, help us understand. At DEA you have warrants, better than subpoenas. You have guns. Why do you need participants in the closed system to do that job?

A. Because, again, our resources are limited. The Controlled Substances Act was set up so a supply chain could police itself all the way down to the doctor and pharmacy level.

THE COURT: Just a minute, Mr. Rannazzisi.

MR. SCHMIDT: Your Honor, I don't think he's an expert on why the Controlled Substances Act was set up. I'll move to strike that testimony and ask that he be limited to his understanding and his role.

THE COURT: Well, Ms. Singer.

MS. SINGER: I think I am, Your Honor. My intention is to ask him of his understanding and what was communicated about the role of participants.

THE COURT: Yeah. I think you can ask him what's in his understanding, but that's all.

MS. SINGER: Okay.

BY MS. SINGER:

Q. So, Mr. Rannazzisi, let me rephrase. What is your understanding of why the closed system was set up to distribute responsibility for maintaining effective controls?

A. Because there -- the closed system was set up to prevent diversion. And the way that they set the closed system up for distribution was to ensure that the registrant population had a function in policing itself as well as, you know, being policed by regulatory law enforcement.

Q. And in your experience, do distributors have the tools to prevent diversion?

A. Absolutely, absolutely. You know, you talked about guns and subpoenas. You don't need a gun or a subpoena to, to police your customers. You know, a gun is just a tool in law enforcement.

You have that same tool. Your Suspicious Order Monitoring Program is your tool. And as far as a subpoena, yeah, it's an investigative tool to obtain information. You don't need a subpoena. You could walk into your customer and ask them the same information. The idea they don't provide it, you just don't supply them anymore.

Q. And in your experience, what happens when the closed system doesn't function?

A. If there's a breach in the integrity of the closed

system, drugs are funneled out of that supply chain into the illicit market. It's a total -- it's a breakdown. A breakdown of the system will cause diversion. And that's -- it's as simple as that. It doesn't get anymore simple.

Q. And did you observe a breach in the closed system during your tenure as Deputy Assistant Administrator?

A. Yes, multiple times.

Q. And did you observe the impact of that breach?

A. Yes.

Q. And what was that impact that you observed?

A. The market being flooded, the illicit marketplace being flooded with opioids, benzodiazepines, mild stimulants, people becoming addicted, people overdosing, police officers required, being required to carry naloxone, which is not part of their duties up until a few years ago when we had to start carrying it because the overdoses were outrageous, and of course, you know, losing loved ones.

Q. All right. Let's turn from the closed system to the next stage in our, in our map and talk about guidance.

Did DEA provide guidance to defendants on their obligations to prevent diversion?

A. Yes, ma'am.

Q. And why did -- why did DEA provide that guidance?

A. Because it was one of those situations where we were seeing large breaches within the closed system of

distribution. We were watching large quantities of drugs leave and going into the illicit marketplace, and we needed to stop it. We needed to stop the hemorrhaging.

So we began an initiative to ensure that they knew what their obligations were under the Act, to reiterate what their obligations were under the Act, and reinforce the fact that they must do their part and help us do our part to police the system, this closed system so drugs will not be diverted.

Q. And when you talk about the Act, Mr. Rannazzisi, what are you referring to?

A. The Controlled Substances Act, Title 21.

Q. Okay. And through -- stepping back from the initiative you were describing, what are the different ways through which the DEA provides guidance to registrants?

A. We, of course, start out by -- we'll provide letters. We'll do face-to-face visits. We'll do inspections and do Q and As and inspections. We'll issue final orders on a registrant investigation where the registrants could see exactly what happened to a particular registrant, why the action was taken, why there was a revocation.

We, we have several methods of, of getting the word out. We do presentations in DEA-sponsored conferences. And that's all the way up and down through the supply chain from, from pharmacists and doctors to distributors up to

manufacturers.

Q. Okay, all right. So let's turn back to the distributor initiative. And I'm sorry. Just to clear up one part of your testimony, when you said you would or you could, are those all things you did when you were at DEA as Deputy Assistant Administrator?

A. Yes. All of those functions of providing notice, providing guidance were done by me and also my predecessors.

Q. Okay. So I think you started to talk about an initiative. What was the initiative you were describing a few minutes ago?

A. The distributor initiative.

Q. And what is the distributor initiative?

A. The distributor initiative was started by -- was started by a team of investigators under then Deputy Assistant Administrator William Walker. And it was started because there was a, a flow of pharmaceuticals, particularly hydrocodone, Alprazolam, and phentermine going into pharmacies from distributors. But those pharmacies were internet-based pharmacies, which at that time were illegal. I mean, they were operating in an illegal manner.

Q. And, and when was it under I think you said Deputy Administrator Walker that the distributor initiative was launched? What year are we talking about?

A. 2005. It was right during transition. I think that

was the last thing he did before he left for military service.

Q. And, Mr. Rannazzisi, you've mentioned some drugs that are familiar to us. But can you, can you explain what Alprazolam is, if I said that right?

A. Yes, ma'am. Alprazolam is a benzodiazepine. The trade name is generally Xanax, but they sell generic brands. It's in a group of class -- a class of drugs called anti-anxiety agents. It's in there with Diazapam, which is Valium, and Clonazepam, which is Klonopin.

So those drugs are given to people to, to treat anxiety. Also two of those drugs are used for, for seizures.

Q. And you mentioned internet pharmacies. So at some point did the DEA turn its attention centrally to dealing with internet pharmacies?

A. Yes. From -- obviously, when we, we started looking at this huge volume of controlled substances going into these internet pharmacies from the distributors, we decided that at that point in time we would, we would shift and start concentrating on, on internet pharmacies that didn't take us away from doctor and pharmacy cases, pill mill type cases.

But those internet pharmacies were an immediate threat that we had to deal with. So we kind of shifted and used the distributors as a choke point to stop that flow.

Q. And what kind of volume were you seeing -- volume of pills coming out of these internet pharmacies?

A. They were -- well, the internet pharmacies were actually facilitation centers. The pharmacies that were supplying those -- the people who were accessing those facilitation centers, those brick and mortar pharmacies, were dispensing millions of tablets in a year.

Some pharmacies would get, you know, in a very short period of time five hundred thousand tablets, and the quantities were outrageous. They are quantities that are not usable that should have immediately struck a cord with somebody who is looking at those, those purchase patterns.

Q. And where were the internet pharmacies getting the drugs?

A. They were getting them from the distributors.

Q. From which distributors?

A. A few distributors, but Amerisource, McKesson, and Cardinal had a big role in those internet pharmacies.

Q. Okay. Let's turn to P-44540, please.

MS. SINGER: Your Honor, may I approach?

THE COURT: Yes.

BY MS. SINGER:

Q. So, Mr. Rannazzisi, I've given you two copies, a color version and a black and white that has the exhibit sticker. You can look at either of them. Can you read

the title of this document?

A. The title of the document is "Internet Pharmacies."

Q. And do you recognize the document?

A. Yeah. This is a standard -- this is a standard presentation that we gave probably right up to 2008, maybe 2009, probably right up to 2008.

Q. And "we" being the DEA; is that right?

A. Yes, the DEA.

Q. All right. And your name is on this presentation; is that right?

A. Yes.

Q. Okay. And is this a presentation that you personally gave?

A. I gave this presentation numerous times.

Q. And do you -- where did you give this presentation or to whom?

A. I gave it to professional medical organizations, pharmacy organizations, law enforcement, IACP, International Association of Chiefs of Police, regulatory agencies, Boards of Pharmacy.

We, we received a lot of requests for information regarding different aspects of the drug problem in the U.S. and the internet was a very big requested presentation.

So we gave that pretty much across the United States. And it wasn't just me. This was one of my presentations,

but there were several people that were giving the same presentation using the same slots.

Q. And did you give this presentation to registrants?

A. Registrants would get the presentation. Generally, they would be in the audience with everybody, with the rest -- especially in those professional organizations, yes. This presentation was also given by people in my office to registrant organizations and advocacy groups.

Q. And was this a presentation you gave as part of your duties at DEA?

A. Yes, ma'am.

Q. And the purpose of the presentation -- you may have spoken to this. But just to be clear, what was the purpose?

A. To basically enlighten the audience on what is happening as far as drug trafficking through internet pharmacies.

Q. And you mentioned the volume. Was there anything else that was troubling to DEA about internet pharmacies?

A. Well, there were a lot of things troubling DEA about internet pharmacies. But you had the volume, the types of drugs, the classes of drugs, the ratio of controlled substances to non-controlled drugs, the amount of drugs going into small areas, the fact that the internet pharmacies that were distributing these drugs had no doctor/patient relationship with their patients, the fact

that the pharmacies were not seeing any patients. All of this really troubled us, yes.

Q. And how would you --

MS. WICHT: I'm sorry to interrupt you, Ms. Singer.

Your Honor, I didn't want to interrupt the witness. I'll just object that, that Ms. Singer is asking questions about things that were troubling to DEA as a whole and the witness is answering them that way. And he's not here to speak for DEA today, and I would ask that he be confined to his own personal knowledge and experience.

MS. SINGER: So, Your Honor, this is a presentation that Mr. Rannazzisi testified he gave while at DEA for the DEA.

THE COURT: Yeah, overruled.

Mr. Westfall.

MR. WESTFALL: Your Honor, --

THE COURT: I thought we'd hear from you.

MR. WESTFALL: As long as he doesn't get into information that's going to be covered by the deliberative process privilege, attorney/client privilege, or law enforcement privilege, we don't have a problem with him giving that information. But anything that's non-public or covered by those privileges he understands he's not allowed to give that information.

THE COURT: Well, I'll overrule the objection for now and we'll see where we go, Ms. Singer.

MS. SINGER: All right. Right now we're on a public presentation, so hopefully we won't get into too much trouble here.

BY MS. SINGER:

Q. Let's turn, Mr. Rannazzisi, to slide 26.

Can you pull that up, please?

MS. SINGER: You know, before we do, I'd like to move to admit P-44540.

MR. SCHMIDT: We'll object, Your Honor, insofar as there's a lot of hearsay in there. If they want to focus on individual parts, we would withdraw it as to individual parts that are proffered, but there's a lot of hearsay in there.

MR. NICHOLAS: We agree. Same objection.

MS. WICHT: I would join that, Your Honor, and just note in addition that I don't think there's been any evidence or any suggestion in this case of any internet pharmacies that have existed in Cabell/Huntington or presented any problem in Cabell/Huntington. So we would also object on geographic scope and relevance.

MR. SCHMIDT: And, actually, one other relevance objection. I apologize, Your Honor.

I think Mr. Rannazzisi's testified that he didn't give

the distributor briefings to the defendants in this case. I don't know that this was ever given by him to us. And, so, on that ground, we'll object on relevance.

THE COURT: Did you give the, this briefing to any of the three defendants in this case, the distributors, Mr. Rannazzisi?

THE WITNESS: I don't believe that I personally gave this presentation to the individual defendants. I gave this presentation to organizations that they may have been present, but not --

THE COURT: I'm going to sustain the objection, Ms. Singer.

MR. ACKERMAN: Your Honor, notwithstanding that won't be -- notwithstanding that won't be moved in, may Ms. Singer question Mr. Rannazzisi about, about the presentation?

THE COURT: Well, if he, if he didn't give the presentation to these defendants, it's irrelevant, isn't it?

MR. ACKERMAN: Well, no, I don't think it is, Your Honor. I think for a couple reasons it would be relevant.

I think, first of all, with respect to the hearsay, he testified that he gave it on behalf of the DEA. So it could be a public record under 803(8)(A)(i) setting out the office's activities.

I think it is offered to rebut a claim that many

defendant witnesses have made earlier, that the DEA changed its interpretation of regulation at some point in time. And this is a prior consistent statement which -- so it's offered for non-hearsay purposes as well.

THE COURT: Mr. Nicholas.

MR. NICHOLAS: Well, I'm not sure I followed all of that reasoning. But, number one, this -- as you said, Your Honor, this was not given to any of the defendants here.

And, number two, as Ms. Wicht said, there's no issue about internet pharmacies in this case.

So I don't think this should be admitted.

THE COURT: I'll sustain the objection.

You can go ahead, Ms. Singer.

BY MS. SINGER:

Q. Mr. Rannazzisi, where did the drugs from internet pharmacies go?

A. They went to brick and mortar -- well, they went to the public. These drugs were -- people would get on the internet, access one of these facilitation sites, and basically order drugs without any kind of oversight from brick and mortar -- that ended up going to them from brick and mortar pharmacies that were supplied by distributors.

Q. And were they limited to any particular geographic area?

A. No. They were across the country.

Q. And across all of the states in your experience?

A. Yes, yes.

Q. And what was the volume of these internet pharmacies, in your experience, compared to traditional pharmacies that DEA had seen before?

A. The internet pharmacies were ordering huge volumes, you know, hundreds of thousands of tablets, you know, in a month because they, they had such a huge, a huge customer base.

And the reason they had a huge customer base was people were using the internet to, to veil their activities, to, to cover their activities. No one knew who the customers were. They were using all sorts of payment methods.

And, so, they were ordering drugs basically in the darkness, you know. So it would be difficult to find them.

Q. And were the signs of an internet pharmacy, the physical appearance, would that also have been a red flag that they were engaged in diversion?

A. Yes.

Q. And what were those signs?

A. Oh, we had internet pharmacies -- we had pharmacies turn into closed-door pharmacies. They would see no patients and they would just start -- they would just be mailing out packages.

We had internet pharmacies that were set up in

warehouses. We had internet pharmacies that were set up in basements.

It, it got to a point where the internet pharmacies were basically if you had a room and you could store drugs, you could open up an internet pharmacy.

Q. And, so, would that have been evident to a distributor if it visited an internet pharmacy that it wasn't a traditional brick and mortar pharmacy?

A. Absolutely.

MR. NICHOLAS: Your Honor, could I object?

I mean, I didn't object to every question about the internet pharmacies, but we're now at a place where I really think this is not relevant and not pertinent to this case or the issues in this case.

MS. SINGER: Your Honor, Mr., -- if I may, Mr. Rannazzisi has testified first that these defendants supplied internet pharmacies. They supplied them in volumes that were unprecedented, and that those pills traveled throughout the country into every state. They are, I think, absolutely relevant to the --

THE COURT: Well, the question was what would have been evident to a distributor, and I'll sustain the objection to that and you can ask the next question.

MR. SCHMIDT: Your Honor, just on the point of the internet pharmacies, he does have a chart in his slides that

were excluded that tracks the trail of internet pharmacies that conspicuously does not go to West Virginia. We don't think there's been a foundation laid for Huntington/Cabell which is what this case is about. Saying it went to all 50 states is kind of a --

THE COURT: Well, I think I've already sustained the objection to the slides.

MR. SCHMIDT: Thank you, Your Honor.

THE COURT: Mr. Farrell.

MR. FARRELL: Yes. What I wanted to point out, Judge, is that as you recall from three weeks ago, we put into evidence already the distributor initiative summaries and the slide decks from those visits to the three distributors.

So the reason the internet pharmacies are important is because in 2005, the volume of pills sold by the distributors to the internet pharmacies triggered the DEA visiting with each of them beginning --

THE COURT: Well, we're not there yet.

MR. FARRELL: Yes, sir.

BY MS. SINGER:

Q. All right. Maybe with the Court's permission, we'll move to those.

Did you, without, without getting into any non-public information, develop a strategy to deal with internet

pharmacies?

A. Yes, we did.

MR. WESTFALL: Your Honor, I don't have -- sorry. This is Fred Westfall. I don't have a problem with him giving a general answer to the question. But if he gets into anything as to how it was developed or why it was developed, we're in the deliberative process and we're in privileged information.

So, again, I think the general answer is "yes." But if we get much beyond that, we're getting into privileged information that the government wants to protect with DEA.

MR. SCHMIDT: And just, without objecting to that objection at all, it does put us in a tough position if he's allowed to say just a little bit and then we can't follow up in our examination.

So we take no issue with the objection, but I think it becomes preclusive because it means Mr. Rannazzisi can give testimony and we can't follow up on it.

THE COURT: Mr. Westfall, you don't have any problem with it so far. You're just concerned about where he might be going next. Right?

MR. WESTFALL: That's correct, Your Honor.

THE COURT: Well, let's wait and see if that problem develops.

MR. WESTFALL: Yes, Your Honor.

BY MS. SINGER:

Q. Did you as part of your internet strategy, again without going into anything that was non-public, turn to meetings with these individual defendants, Mr. Rannazzisi?

A. We met with the individual defendants, yes.

Q. And what was the reason for those meetings?

A. To discuss their obligations under the Controlled Substances Act and show them very specific instances of, of distribution that should have triggered some type of query into the, into the orders and due diligence.

Q. And what -- were those meetings part of the distributor initiative that you were talking about earlier?

A. Yes, those would have been the distributor initiative.

Q. So let's turn to -- all right. Did you participate in the distributor initiative meetings?

A. No. My staff did -- I only, I only participated in one distributor initiative meeting.

Q. And were you -- and which one was that?

A. It was the second follow -- it was the follow-up to the initial McKesson meeting.

Q. And were you briefed on the distributor initiative meetings that DEA had with each of these defendants?

A. Yes. We were -- we were briefed. I was briefed on every distributor initiative meeting that occurred at

headquarters, yes.

Q. And how were you briefed?

A. Generally, after the meeting we would sit down, hand in materials, and go through and tell me what actually went on in the meeting, what questions were asked, things like that.

Q. And in addition to the, the personal briefing, did you also receive any written summaries of those meetings?

A. Yes. I was -- I required them to give me all the written summaries in a memo form. And that memo, I retained a copy in my office. There was copies given to two other, two other sections within the Office of Diversion Control.

Q. And when were those summaries provided to you?

A. Probably within the month after the presentation.

Q. And was it ever provided to you more quickly than that?

A. Oh, absolutely. But, you know, things happen during the vetting process, so sometimes it takes a little longer.

Q. And who prepared those summaries?

A. Depends who the principal briefer was.

Q. And can you remember any of the individuals at DEA who were involved in those briefings?

A. Could have been Mapes, Mike Mapes, could have been Barbara Boockholdt. It could have been any number of the liaison policy chiefs. It depends on who was, who was going to write the memo and who was at the meeting, who took the lead at the meeting.

Q. And are these individuals who you mentioned all people within your direct reports?

A. Yes, they were all direct reports.

Q. And were the summaries and the oral briefings you received prepared and shared with you as part of the DEA's regular duties?

A. Yes. Any time we had a meeting like that, a memo had to be done and it had to be filed, yes.

Q. And did the DEA present standard material -- did the DEA present any materials during the distributor initiative meetings with the defendants?

A. The --

MR. SCHMIDT: Objection, foundation. He has testified he wasn't there.

THE COURT: Just a minute. I'll overrule the objection.

BY MS. SINGER:

Q. Go ahead.

A. The presentation had --

THE COURT: I think you objected on foundation. I think she's laying the foundation right now, Mr. Schmidt. So the objection is overruled.

MR. SCHMIDT: I'll also object, then, on hearsay.

THE COURT: All right.

MR. FARRELL: I will point out, Judge, this is

a -- we resolved this several weeks ago. These documents are in evidence.

THE COURT: They're already in evidence?

MS. SINGER: Some of them are.

THE COURT: And some of them aren't. Okay, all right.

BY MS. SINGER:

Q. I'm sorry. Where were we?

Are you aware whether there were materials presented to defendants during these distributor initiative briefings?

A. Yes.

Q. And did you see those materials?

A. Yes.

Q. Did you approve those materials?

A. Yes.

Q. And what did those materials cover generally?

A. Well, the materials had, had case law, slides on case law. So those were standard -- there were certain slides that were standardized to the distributor initiative briefing. Then there were other slides and other information that were specific to that particular distributor.

MS. SINGER: So I'm going to ask that we circulate P-09114, P-12805, and P-09112.

Your Honor, may I approach?

THE COURT: You may.

BY MS. SINGER:

Q. I have gummed up the works by doing three documents at once. I apologize.

So, Mr. Rannazzisi, while we're passing these around, can you look at each of these documents and let us know whether you recognize the documents.

Why don't you start with 9114 and let me know when you have that up, please.

A. I have it.

Q. Okay. And what is that -- what is the subject of that document?

A. It's a meeting with Cardinal Health.

Q. And what is the date of the document?

A. The date of that document -- of the document is August 23rd, 2005.

Q. And do you recognize the document?

A. Yes.

Q. What do you recognize it to be?

A. It's the closing memo from the meeting that occurred with -- it's just an analysis of what happened at the meeting.

Q. Okay. And who is the memo addressed to?

A. It's addressed to Joseph Rannazzisi, me.

Q. Okay. And who was it from?

A. Michael Mapes.

MS. SINGER: Your Honor, I'd move to admit P-9114.

MS. WICHT: Your Honor, we'll object on the basis of hearsay and relevance as to geographic scope for the reasons that we discussed earlier about the internet pharmacies.

MR. ACKERMAN: Your Honor, --

THE COURT: All right. Do I hear from the other side here?

I assume all -- that's an objection for all the defendants, Ms. Wicht.

MS. WICHT: Well, I would probably assume that's correct too, Your Honor, although this is the memo that's about Cardinal Health in particular which is why I stood up and --

THE COURT: Oh, okay.

Mr. Ackerman.

MR. ACKERMAN: All right, Your Honor. So this document is a public record. Federal Rule of Evidence 803(8)(A)(i), it is a record or statement of a public office that sets out the office's activity. There is no indication of untrustworthiness per 803(8)(B). And, therefore, it's admissible on that ground.

It is also offered for non-hearsay purposes for notice to establish that the communications were made to Cardinal.

THE COURT: Well, I could also admit it as a record that it's regularly conducted activity based on the questions Ms. Singer asked him, couldn't I?

MR. ACKERMAN: I think you could as well, yes.

THE COURT: All right. The objection is overruled. It's admitted.

BY MS. SINGER:

Q. All right. And, Mr. Rannazzisi, after the, the initial closing memo, as I think you referred to it, do you recognize the pages that follow?

A. Yes, ma'am. This is the distributor -- this is the PowerPoint that's used in the distributor briefing.

Q. And was this the PowerPoint that you reviewed and approved?

A. Yes.

Q. And was it -- what was its purpose again?

A. To basically explain what the problem is, explain what the obligations are under 823 --

THE COURT: Let me interrupt you and just clean up the record here a little bit.

You objected based on relevancy as well, did you not, Ms. Wicht?

MS. WICHT: Yes, Your Honor.

THE COURT: How is this not relevant?

MS. WICHT: Your Honor, because, again, it relates

to internet pharmacies and it's the same geographic issue that we had discussed earlier with respect to the lack of evidence of internet pharmacies in this case at all, Your Honor.

MR. SCHMIDT: And just to get this out of the way on a recurring basis because we have our memos coming up, we have the same objection.

But even -- I would add one more thing. Even if he is allowed to talk about it, he's now interpreting what the slides mean and what they said to distributors. That is certainly not proper. That's hearsay at best.

MS. SINGER: So --

MR. NICHOLAS: I just -- you will appreciate this. I will not be objecting to the AmerisourceBergen version because it's already in evidence. So --

THE COURT: Well, I'm going to overrule the objection. I think it -- I think it is -- even though it embraces much more than the geographical area we're involved with here, I think it certainly has relevance to what the individual defendant here was told, which would cover, I assume, all of their operations which would embrace the geographical area.

So I think it's relevant for that reason and other reasons and I'll overrule the objection.

MS. SINGER: And --

THE COURT: Now, as far as the, the attachments, the slide presentation, where are you going to go with that?

MS. SINGER: I am not planning to explore it, Your Honor, except to ask him a few questions related to the guidance that DEA provided to these defendants.

So the witness has testified that these slides were the slides he approved and that were shared with defendants at each of these briefings.

THE COURT: Has he testified to that?

MS. SINGER: He did.

THE COURT: Mr. Farrell, do you want to get your oar in the water here?

MR. FARRELL: Yeah. Before we rehash it, this is the exact same slide deck that was used that's already in evidence with AmerisourceBergen.

THE COURT: Okay.

Ms. Wicht.

MS. WICHT: I'm sorry, Your Honor.

On the slide deck, I'll just object on the basis of foundation to the extent that he's purporting to describe what was said in the meeting when he wasn't present for the meeting.

MR. SCHMIDT: Yeah. And that's what distinguishes Mr. Farrell's example. It's one thing to bring these in for an expert and say this is what they show. It's another

thing for someone to testify about a meeting he was not at.

MS. SINGER: So, Your Honor, if I may, Mr. Rannazzisi testified that he reviewed this deck. He approved this deck.

BY MS. SINGER:

Q. And, Mr. Rannazzisi, if I may, just to add one other piece to the foundation, did you direct your staff to provide this, this presentation to each of the defendants when they met with them?

A. Yeah, this -- the deck was -- yes, the deck was part of the binder of information that they received when they met.

THE COURT: Did you go over the slides ahead of time and approve them?

THE WITNESS: I went -- since all of these slides are standardized, Your Honor, I did go over them. I didn't go over every, every time this presentation, but they always used the same standardized slides with the exception of the slides that used the ARCOS data. And those slides I did not go over.

THE COURT: You get one more try, Ms. Wicht.

MS. WICHT: Respectfully, Your Honor, I think the foundation that has been laid would allow him to say this is what's on the slide which, of course, the Court doesn't -- I would submit doesn't need him to do. But it would not allow him to say this is what was said to Cardinal Health because

he wasn't there for that.

MS. SINGER: Your Honor, again, I think Mr. Rannazzisi has said that within his sphere of authority, this was the presentation he approved, directed his staff to give, and that his staff sent back summary memos which described what happened at this meeting, including the presentations of the slide deck.

THE COURT: I'm going to overrule the objection and admit it.

BY MS. SINGER:

Q. Mr. Rannazzisi, just for the record, can you turn to Bates Number Page 13, please. It has a very darkened picture of an internet pharmacy at the top, and it has a summary slide. So it has Page Number 12 to confuse you.

A. I have it.

Q. And can you read the last bullet on that summary slide?

A. "Not limited to internet pharmacies."

Q. And was it your understanding that the guidance that DEA provided at these meetings related more broadly -- or was it directed more broadly than just internet pharmacies?

A. Yes, ma'am. The presentation followed the regulations.

MS. WICHT: Your Honor, I -- the witness has already answered, but I would just preserve our objection to that last question.

THE COURT: The objection is overruled, but the

record will show it was made loud and clear.
BY MS. SINGER:
Q. All right. Let's move, without too much trepidation, then, to P-09112 which was -- I'm sorry. That's the wrong one. P-12805. Let me know, Mr. Rannazzisi, when you have that one in front of you.
A. I have it.
Q. Okay. And what is the subject for that memo, or that document?
A. "Internet Presentation with McKesson Corp."
Q. And the date of that memo?
A. September -- the date of the memo is October 20th, 2005.
Q. And do you recognize this document?
A. Yes, I do.
Q. What is it?
A. It's a summary of the internet pharmacy presentation done for McKesson Corp.
Q. And who is the memo addressed to?
A. Joseph Rannazzisi.
Q. And who is it from?
A. Michael Mapes.
Q. And what does this memo describe?
A. The memo discusses who was at the presentation and what was discussed and any significant detail -- any significant

thing that happened at the meeting.

Q. And do you recognize the pages that follow that memo?

A. Yes. It's the same presentation that's been given.

Q. And was that the presentation that DEA gave to McKesson?

A. Yes.

MS. SINGER: Your Honor, I'd move to admit P-12805.

MR. SCHMIDT: We'll just preserve our objection on geographic scope and relevance, and if I may do that just on a running basis.

THE COURT: All right. Yes, you may. And I'm going to admit it using the same rationale that I admitted the one relating to Cardinal Health which was 9114.

MR. SCHMIDT: Thank you, Your Honor.

BY MS. SINGER:

Q. Mr. Rannazzisi, just to close out the record, do you also have in front of you P-09112?

A. Yes, ma'am.

Q. And what is that document?

A. That's, again, another memorandum on the internet presentation for AmerisourceBergen.

Q. Okay. And do you recognize this document?

A. Yes.

MS. SINGER: This one is already admitted, Your

Honor.
BY MS. SINGER:
Q. All right. Do these presentations and summary memos accurately reflect the guidance that DEA provided to these defendants at the distributor initiative meeting?
A. Yes.
MR. SCHMIDT: Objection, foundation. He wasn't there.
MS. WICHT: Join.
THE COURT: Well, Ms. Wicht, do you want to --
MS. WICHT: No, Your Honor. I was simply --
MR. NICHOLAS: I have -- I would register the same objection.
THE COURT: Well, I think he's testified that these memos reflect guidance given to the defendants at the meetings that are recounted in the, in the exhibits and I'll overrule the objection.
BY MS. SINGER:
Q. Go ahead, Mr. Rannazzisi. Please answer.
A. Could you repeat the question, please?
Q. Sure. Do these presentations and summary memos accurately reflect the guidance DEA provided to these defendants at the distributor initiative briefing?
A. Yes.

Q. Now, do these distributor initiative briefings happen in person?

A. These three were all in person, but we did distributor initiative meetings by phone. But these three were in person, yes.

Q. And why did they take place in person?

A. Well, because we wanted to sit down with them, talk to them, look face-to-face, and answer any questions they have. That was, that was important to us. We wanted to understand the seriousness of the problem that we were dealing with and give them every opportunity to ask questions.

Q. And I think you mentioned who participated from DEA. Do you know who -- what type of staff participated from defendants?

A. Well, we had asked for senior managers, senior managers within their, their headquarter's hierarchy I guess.

Q. And can we turn back for a moment, Mr. Rannazzisi, to P-12805 which is the McKesson briefing?

A. Yes.

MS. SINGER: And can we put it up, please?

BY MS. SINGER:

Q. And can you take a look at the last paragraph. And what does the last paragraph say?

A. "Mr. Mapes finalized the presentation by advising the representatives of McKesson that they needed to thoroughly

review the materials which had been presented to them and review in-depth the purchasing patterns and quantities of their customers. Representatives of McKesson acknowledged understanding of the material presented."

MR. SCHMIDT: Object to the hearsay within hearsay in the last sentence.

MS. SINGER: This is a party admission, Your Honor, particularly in light of defendants' repeated representations that they did not understand the guidance that was provided.

THE COURT: Mr. Ackerman.

MR. ACKERMAN: She said it all, Your Honor.

THE COURT: Objection is overruled.

BY MS. SINGER:

Q. One of the slides -- and we can pull that down. One of the slides covered a Supreme Court case. Are you familiar with that?

A. There were two Supreme Court cases, *Moore* and *Direct Sales*.

Q. Okay. Let's focus on *Direct Sales*. Was there a reason you included *Direct Sales* in the, in the distributor initiative briefings?

MR. WESTFALL: Objection, Your Honor. To the extent that he's relying on opinions of general counsel for the in-house counsel with DEA, it's covered by the

attorney/client privilege. I'd object to any kind of disclosure of attorney/client privilege information.

THE COURT: Do you agree with that, Ms. Singer?

BY MS. SINGER:

Q. Mr. Rannazzisi, can you answer that question without disclosing privileged information, meaning without --

A. I understand. The slide deck that was prepared was prepared. There were -- there was input. But just on the cases, I believe the cases we, we picked ourselves because *Moore* was -- *Moore* and *Direct Sales* are very well-known cases related to diversion.

THE COURT: Well, he said there was input. I'll sustain the objection and you might be able to ask him a question that gets around that problem.

BY MS. SINGER:

Q. So, Mr. Rannazzisi, without discussing any input or advice from counsel, what did you want to communicate by including *Direct Sales* in the presentation?

A. *Direct Sales* was a case that involved a distributor that was back in the 19-, late '30s, early '40s, mid '30s, early '40s. And it involved the distribution of morphine, small multi-grain tablets of morphine to a doctor.

And the purchase patterns from that doctor were, were extremely large and they were an anomaly. And we included

Direct Sales to show that even back in the '30s and '40s there was an obligation from a distributor to ensure that the customers were, were not diverting drugs, that they were actually getting those drugs for a legitimate medical purpose.

So that's why *Direct Sales* was included, and *Moore* was included -- discussed the legitimate patient -- the obligation of a doctor to prescribe for a legitimate medical purpose in the usual course of professional practice.

Q. So let's turn in the McKesson presentation, if you still have that in front of you, --

A. Yes.

Q. -- to slide eight, which is Page 10 on the Bates number. It says "Suspicious Orders" at the top. Have you found it?

A. I can just go off the screen.

Q. Okay, all right. Looking at the slide on suspicious orders, what guidance was DEA providing -- or was DEA providing at this presentation regarding reporting a suspicious order -- I'm sorry. Let me just read it, withdrawing the question.

"Reporting a suspicious order to DEA does not relieve the distributor of the responsibility to maintain effective controls against diversion."

Have I read that slide correctly?

A. Yes.

Q. Okay. And what guidance was DEA providing in that slide?

A. Just reporting an order does not relieve the, the distributor of, of doing their due diligence. So if they, if they report the order but ship, ship the order, that's not maintaining effective controls against diversion if they don't resolve the suspicions within the order.

So if, if it's an order that's suspicious, you either resolve and ship or you report. But you can't say, well, it's suspicious. Here's the order. Oh, and, by the way, we shipped it or they just shipped it. That's, that's what that slide was saying.

Q. And moving to the, to the next slide below that, it says, "DEA cannot tell a distributor if an order is legitimate or not. Distributor must determine which orders are suspicious and make a sales decision."

Have I read that correctly?

A. Yes. That's absolutely correct, yes.

Q. Okay. And what did DEA mean when -- what guidance was DEA providing with that second bullet?

A. Well, DEA's not in a position to determine whether an order should be shipped or not. It's a business decision. And this is why. We don't know the customer. We don't know where the customer sits. We don't know the demographics of

the area. We don't know historically what the customer has purchased, what he hasn't purchased, how many times he's been questioned on his purchases. We don't know if he's near a hospital or a hospice center or a palliative care center. We don't know any of that.

So we can't make that due diligence -- do that due diligence review and then make that decision because we don't have any of that information. And even if we did, we couldn't do that on a daily basis because all of our investigators and our agents would be tied up doing those, those decisions rather than doing what they're supposed to be doing which is policing the supply chain and doing investigations.

Q. Okay. Now, during the distributor initiative briefings, does the presentation in the slide deck also provide examples to distributors to these defendants of suspicious orders?

A. That was the whole basis of the, of the distributor initiative. That's exactly what they were supposed to be doing, showing real-life examples.

Q. So let's turn to the next slide.

THE COURT: What's the purpose of reporting the suspicious orders?

THE WITNESS: We report the -- they report the suspicious orders, and then we take the suspicious orders

and, and do a follow-up, look at the order, look at the customer.

The suspicious order is -- think of it as a pointer system. Here's an order that we found suspicious. We didn't ship the order. We need to look at this. And that's -- and we would take it from there.

BY MS. SINGER:

Q. Mr. Rannazzisi, following up on the Court's question, why is it, why is it that -- did DEA provide guidance to defendants on why they shouldn't ship a suspicious order?

A. Yes.

Q. What happens -- I'm sorry. Why does a distributor have to block a suspicious order? Why is that important?

A. Because if the order is suspicious and it's unresolvable, they can't resolve the suspicions in the order, chances are that order is going to be diverted down the road, somewhere down the road.

If a pharmacy is ordering a quantity that they can't resolve, they're just facilitating diversion by continuing to ship to that pharmacy.

Q. And --

MS. WICHT: Your Honor --

I'm sorry to interrupt again, Ms. Singer.

I just would object to that answer which was full of

speculation on causation that there's no foundation for.

MR. SCHMIDT: We join in that, Your Honor.

MR. NICHOLAS: As do we.

THE COURT: I'll sustain that objection.

BY MS. SINGER:

Q. So let me ask it differently. How long does it take DEA to, to act on a suspicious order report?

A. To -- you're going to have to clarify the question.

Q. So can DEA -- when DEA receives a suspicious order report, what's already happened with the drugs that are covered by that suspicious order report?

A. Well, nothing should have happened with those drugs. Those drugs should have never been shipped.

Q. And if they were shipped?

A. Well, there's a chance that they could be diverted if they were shipped.

Q. And that would happen before DEA ever receives the suspicious order report; correct?

A. Yes.

Q. All right. So let's -- if we may turn to Page 9, which is Bates Number 11 on the slide.

Do you recognize these slides, Mr. Rannazzisi?

A. Yes.

Q. And what are they?

A. These are slides that just show a purchase pattern or a

pattern of, of pharmacy purchases that could -- things that should trigger a due diligence review.

Q. Okay. And, and let's turn to the next example, so the next slide, please.

So is there a second example that was provided in the distributor initiative briefing?

A. Yes.

Q. And were those other red flags that DEA explained to distributors?

A. They're things that a distributor should look at when questioning and performing due diligence on a specific order, yes.

Q. And did you provide a third example?

A. Yes.

THE COURT: You said DEA followed up on a suspicious order. Did DEA follow up on every suspicious order report you see?

THE WITNESS: That's, that's a question that, unfortunately, the department's directed me not to answer questions on what we do with the suspicious orders because it gets into the investigative process and also communication between -- the investigative communication between --

MR. SCHMIDT: If that's the case, Your Honor, then we move to strike his testimony on suspicious orders. The

idea that he can come in and make allegations about suspicious orders and not even answer the Court's basic question of whether they did anything about it, that's not fair to us.

THE COURT: Well, I'm confused and I probably shouldn't stick my nose in this that deeply, but I'm confused. The witness testified about the lack of person power and resources to do these investigations.

And then if I understood you correctly, you said you followed up on all the suspicious order reports. How did you rationalize those two propositions, --

THE WITNESS: Yes, Your Honor.

THE COURT: -- Mr. Rannazzisi?

THE WITNESS: We did follow up on suspicious orders. But understand the volume of suspicious orders that should come in is not a huge quantity of orders. It shouldn't be like boxes of orders. It should be a very specific order that outlines why it's suspicious, what triggered the suspicion, what triggered the order, what's the historical ordering pattern. And then we would follow up.

But, but we're not talking about 100, 1,000 orders. We're talking about specific suspicious orders. And that, that -- I can't go over every order. But if you do suspicious orders appropriately and correctly, you're not

going to get 1,000 suspicious orders coming into a, to DEA in one day.

What you will get is suspicious orders go into the offices that if they're done appropriately, the agents could use -- agents and investigators can use that to build cases.

MR. SCHMIDT: And, Your Honor, our objection still stands. He did not answer Your Honor's question, which is: Do you follow up on all of them? I think by design he didn't answer that question.

If we're not allowed to ask him about the details of individual suspicious orders, particularly the relevant ones in this community, whatever his Goldilocks standard is for just the right amount of suspicious orders, then we can't fairly examine him. The testimony should be stricken.

MR. NICHOLAS: I think just to -- I agree and I would only add that it is a contested issue as to whether the DEA did do anything with suspicious orders. I mean, we don't agree, and we're challenging that statement.

And if we don't have the ability to, to hear the witness testify about it, we -- it's like we're on ice without ice skates or something. We don't have any footing. We can't deal with it.

THE COURT: Let me make sure I understand the issue here.

The question was probing the, the policies of DEA with

regard to suspicious orders.

And your objection, Mr. Westfall, was that that would get into their internal regulations and that's outside the scope of the two leading authorizations.

MR. WESTFALL: I think if it gets into individual cases of what was happening with suspicious orders except probably perhaps the defendants because anything that they've discussed, that's a little bit different situation, but getting into all the others as far as what happened on an individual basis with each suspicious order I think would be a problem, Your Honor.

MS. SINGER: Well, Your Honor, if I may, what I understand the guardrails to be here is that Mr. Rannazzisi can talk about the general practice of the DEA in dealing with suspicious orders. And I think what he's also talking about here are excessive purchase reports, which I'm happy to go into to help address the Court's question.

But what he can't do is talk about a particular suspicious order, what the basis for that was, how DEA investigated that order. And I think that is completely consistent with the defendants' ability to probe generally what DEA did or didn't do, as defendants' own motion makes clear.

Mr. Rannazzisi is not here to testify about suspicious orders in West Virginia. He's not an expert. His testimony

is limited as a matter of their motion to his prior deposition which didn't relate to suspicious orders in West Virginia.

My questioning and the Court's question here relates only to the general practices of the DEA which they are absolutely free to explore.

MR. NICHOLAS: Just one thing. I thought the Court's question was pretty direct to Mr. Rannazzisi: "Well, did you investigate suspicious orders?" And his answer was, "I can't answer that question."

He didn't -- he was unable to say anything about investigating any suspicious orders. So I really think we're just not in a position to explore any of this.

MR. SCHMIDT: We're here trying a case on Huntington/Cabell where there's been a suggestion that not reporting suspicious orders, with the shifting definition of what that constitutes, that not reporting can lead to diversion.

That only can be true if they acted on them. And if we can't say, well, what happened in Huntington/Cabell, did anything ever happen with them, then we're getting the opinion without the ability to challenge it.

MS. SINGER: So there's no opinion, if I may, Your Honor. What -- we have here the senior most DEA official responsible for the DEA's handling of diversion. These

defendants have said from the minute we came in that DEA didn't act to catch them at diverting drugs.

Mr. Rannazzisi is explaining the guidance that he provided to defendants in dealing with this. But, frankly, whether or -- whether or not defendants did -- whether or not DEA did anything with respect to these suspicious orders, their obligation was to report and, as Mr. Rannazzisi just explained, not to ship these suspicious orders.

But Mr. Rannazzisi is here to explain what DEA's policies and practices are, and defendants will be free to cross-examine him on that.

MR. NICHOLAS: Your Honor, just one more thing which is that we sought discovery. We sought discovery on what the DEA did with regard to suspicious orders in West Virginia and were blocked from obtaining that discovery.

MR. SCHMIDT: And just because it was such an inflammatory statement, our allegation is not that they didn't catch us. That's absolutely not our allegation.

Please don't interrupt. I didn't interrupt you.

Our allegation is that they -- the plaintiffs in this case and Mr. Rannazzisi are trying to blame us for other actors that were regulated by the DEA; and in this case, actors outside of Huntington/Cabell.

THE COURT: Well, your objection, Mr. Westfall, is

that the specifics of individual investigations and the -- am I understanding you correctly?

MR. WESTFALL: That's correct, Your Honor, dealing with the law enforcement privilege to get into any details about what was done with regard to specific suspicious orders as far as what kind of follow-up was done and things of that nature. If it gets into investigative techniques, then that type of information is protected under the law enforcement privilege.

THE COURT: Well, I'll sustain the objection to that. But I don't see why you can't ask him generally what the policies and procedures were.

Do you object to that, Mr. Westfall?

MR. WESTFALL: No. I think he can ask a general -- answer questions generally what the public, what was publicly known about what they did on this.

THE COURT: When I get in a jam, I consult counsel.

(Pause)

THE COURT: Well, I think --

Mr. Nicholas.

MR. NICHOLAS: Well, I don't want -- maybe, maybe you'll address whatever I was going to say.

But what I would say is even if he's allowed to give some sort of general answer as to what DEA generally

supposedly did or didn't do with suspicious orders does not really solve our problem because we're not permitted to, to probe as to what they actually did with suspicious orders in Cabell County and Huntington, which is exactly the information we tried to obtain and were prevented from obtaining from the DEA.

So I don't want to anticipate the Court's ruling, but I don't think such an outcome would resolve our issue.

THE COURT: Well, I don't think my question went to the problem that Mr. Westfall raised. It was a very general question and the witness said he couldn't answer it and that got us into this quagmire.

But I'm going to sustain the objection to any questions about specific investigations in Cabell/Huntington. But if you want to ask him general questions about overarching policies and things, then I think I'll permit that and you may go ahead.

And to that extent, I'm going to overrule the objection that's on the table now. But I don't want to cut you off from raising it again depending on where we go because I don't know where we're going to go.

MS. SINGER: All right. Thank you, Your Honor. I'll resume, although in fairness I think it was your question. And, so, I think --

THE COURT: Well, there's a lesson in that for the

Court. Don't ask any questions.

BY MS. SINGER:

Q. I think what Your Honor had asked, and if I may follow your lead, what did DEA do as a matter of general practice with suspicious order reports that were received from defendants around this time period of 2005-2006?

MR. NICHOLAS: I will object to the, to that question as, as vague, probably misleading, and not, not designed to elicit any probative information.

THE COURT: Mr. Farrell, Ms. Singer, whoever wants to talk.

MR. FARRELL: Judge, what I wanted to point out, in fairness to all of my colleagues here, is, as you can probably tell, this is not a new argument between the parties, nor is it a new argument with the Department of Justice.

The *Touhy* line has been debated all the way back in the MDL. And, so, I think what we're really getting to here is, is to the heart of it, what was going on at this period of time, what was being reported and, in general, how was the DEA reacting.

I don't think anybody in the courtroom believes that that falls within the *Touhy* prohibitions. But, again, this is something --

THE COURT: Okay. I'll overrule the last objection and you can press on, Ms. Singer.

BY MS. SINGER:

Q. Okay. Can you answer that question, Mr. Rannazzisi?

A. Could you repeat it?

Q. I was afraid you were going to say that.

Mr. Rannazzisi, what was DEA doing as a matter of general practice and policy with suspicious order reports received from defendants in 2005 and 2006?

A. If they were truly suspicious order reports, true suspicious order reports, they would be followed up on.

MS. SINGER: And I would like to show the witness P-14288ii.

May I approach, Your Honor?

BY MS. SINGER:

Q. Mr. Rannazzisi, do you recognize the document that I just showed you, or the type of document that I just showed you?

A. This is a sales -- or an Ingredient Limit Report, but it just is -- it's talking about sales, particular pharmacies.

Q. Do you recognize -- do you recall seeing reports like this when you were at DEA?

A. Yes.

Q. And in what context did you see these kinds of reports?

A. These were not suspicious order reports. These were Ingredient Limit Reports, excessive purchase reports, whatever you want to call them, but they're not a suspicious order report.

This is just a -- I don't even know what the time frame is in this one. Oh, it's a month -- this is a monthly report. So what this has is for April, 2007, all of the sales that were above a certain quantity.

Q. And do you know who -- do you know who generated this report?

MS. WICHT: Your Honor, I'll object on the basis of foundation.

MR. ACKERMAN: Your Honor, this is a stipulated document that's in evidence.

MS. WICHT: It is in evidence. I agree, Your Honor. I'm objecting to the foundation to question this witness about it.

MR. ACKERMAN: He just said he recognized it.

THE COURT: Well, this has already been admitted?

MS. SINGER: It's been admitted and the witness has testified that he recognized the document.

THE COURT: Well, I'll overrule the objection and we'll see where we go.

THE WITNESS: This is a standard report that

was -- that would be sent in. And all, all of the -- many of the distributors would send these reports, not necessarily calling them Ingredient Limit Reports, but they'd call them something else, excessive purchase reports, whatever. But it's just a standard monthly report.

BY MS. SINGER:

Q. Okay. And who -- which, which entity generated the report that's in front of you?

A. This one was from Cardinal Health.

Q. And what was it called?

A. Ingredient Limit Report.

Q. And do you see a date on this report?

A. April of 2007 was the month. And it was a run date of May 6th, 2007.

Q. Okay. And is this typical of the kind of reports that DEA was receiving from these defendants in 2005 and 2006?

A. Yeah, these, these are excessive purchase reports that we would get. It's -- they all have different -- they all have different set-ups, but these are the same reports that basically just talk about sales that were over a certain ingredient limit or threshold, whatever you want to call it.

Q. And were these reports provided to DEA at the time the order was shipped?

A. I -- this report is a monthly report, but it's not a suspicious order report. There's no, there's no indication

of why they thought any of these things were suspicious. It's an Ingredient Limit Report.

A suspicious order report, like I said before, is a very specific report. It shows why there's a suspicion. It shows why it's been triggered as a, as a suspicious order.

All this is is a sales, sales to different pharmacies and hospitals and based on the ingredient limit purchase, which is not a suspicious order.

And I don't even know if this was done in real-time because, remember, a suspicious order is supposed to be done when discovered according to 1301. This looks like just a monthly report. It's not a suspicious order report.

Q. And during the 2005-2006 period where DEA was meeting with these -- met with these defendants in the distributor initiative briefings, is that the kind of reporting that DEA was getting from them in lieu of suspicious order reports?

MR. SCHMIDT: Objection, vague. I don't think -- I apologize. I don't think he has that foundation as to McKesson. And the only document that's in evidence on this point is to the contrary.

MR. NICHOLAS: Same objection on behalf of AmerisourceBergen.

MS. WICHT: Same objection, Your Honor.

THE COURT: I'll sustain the objection, but I'm not going to cut you off from this line if you can ask him a

more specific question and get around it. But I'll sustain the objection to that question.

BY MS. SINGER:

Q. All right. Mr. Rannazzisi, did you get a similar report from McKesson that you're looking at from Cardinal, this kind of excessive purchase report?

A. All three distributors sent some type of report, but it wasn't -- they weren't suspicious order reports. So if -- yes, I think -- yes, we received these type of reports. The office received these type of reports as excessive purchase reports, but not suspicious order reports.

Q. And were these reports useful to DEA in detecting diversion?

A. We accepted the reports because if you're going to send us things, we, you know, obviously if we get a chance, we'll look at them. But as you can see the volume of this, without knowing why it's suspicious, without understanding why the company felt that this was, quote/unquote, suspicious doesn't tell us anything. It's just an excessive purchase report.

It needs to be more than that. It needs to be when discovered. It's not a monthly report. Those drugs have been shipped already. I need to know when they were discovered. I need to know why you think it's suspicious.

It's your customer. Tell me why it's suspicious. What

triggered the suspicion, and what did you do to resolve it?

This is -- this doesn't say that. This is just a -- and this is the same -- we've been seeing these since I was, since I was diversion investigator, just volumes of, of, volumes of, of transactions with no guidance on why.

MR. NICHOLAS: May I just interpose an objection to suggest that the witness is offering legal conclusions as to whether these are suspicious orders or not. He's just offering a legal conclusion as far as I can tell.

MS. SINGER: I think Mr. --

THE COURT: Well, --

MS. SINGER: I'm sorry, Your Honor, please.

THE COURT: Go ahead.

MS. SINGER: Okay. I'm sorry. I think he has just testified that these weren't suspicious order reports. They didn't comply with the requirement that they be reported promptly.

And to the point that, you know, what DEA was doing with these reports, I think Mr. Rannazzisi has testified that the whole purpose of a suspicious order report is to allow the DEA to identify and stop diversion. He's described these as after-the-fact shipment reports.

MR. ACKERMAN: Your Honor, if I may, I think the distinction is that Mr. Rannazzisi is opining on the reports and not on the orders within the reports.

MR. NICHOLAS: Well, I think --

THE COURT: Let me hear from the other defendants here.

Mr. Schmidt, did you want to say something?

MS. WICHT: I think Ms. Singer's argument basically said it all. He's opining on whether the reports comply with the regulations. It's a legal conclusion. It doesn't have to do with whether it's, the order is in it or not. He's opining about whether the reports comply with the law which he's not permitted to do.

THE COURT: I'll sustain the objection.

BY MS. SINGER:

Q. Did you, did you provide guidance to defendants on whether these reports were suspicious order reports?

A. I personally, I personally did not.

Q. And did DEA, to your knowledge, provide feedback to these defendants that these were not suspicious order reports?

A. Yes. It was in the letters. Also, we talked about it in the -- it was discussed in the distributor initiative briefings. It was discussed in the letters. It was discussed in court, court documents, the final orders. Yes, it was discussed.

THE COURT: When you get to a stopping place, Ms. Singer, we're going to --

MS. SINGER: We can stop now, Your Honor.

THE COURT: Is this a good place?

Mr. Rannazzisi, I'm going to have to make you come back in the morning.

THE WITNESS: That's all right, Your Honor.

THE COURT: Be here ready to go at 9:00.

THE WITNESS: I will be. Thank you very much.

THE COURT: Until then, you're excused.

THE WITNESS: Thank you, sir.

THE COURT: And I'll see everybody at 9:00.

(Trial recessed at 5:02 p.m.)

CERTIFICATION:

I, Ayme A. Cochran, Official Court Reporter, and I, Lisa A. Cook, Official Court Reporter, certify that the foregoing is a correct transcript from the record of proceedings in the matter of The City of Huntington, et al., Plaintiffs vs. AmerisourceBergen Drug Corporation, et al., Defendants, Civil Action No. 3:17-cv-01362 and Civil Action No. 3:17-cv-01665, as reported on June 7, 2021.

S\Ayme A. Cochran
Reporter

s\Lisa A. Cook
Reporter

June 7, 2021
Date

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